

STEP THERAPY AUTHORIZATION REQUEST FORM

Livalo - Step Therapy - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:		Prescriber Name:	
Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Line of Business:	Medicare	NPI:	State Lic ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	
	ITED REVIEW: By checking this bo rollee or the enrollee's ability to r	 	2 hour standard review timeframe may seriously jeopardize
Strength:			
Directions / SIG:			
Q1. Has the pate A) atorvastatin, B) lovastatin, C) pravastatin, D) rosuvastatin, E) simvastatin, F) ezetimibe/sim	ent tried at least TWO of	owing questions an	d sign.
Q2. Duration: 12 months Q3. Additional Ir	oformation:		
QS. Additional II	Prescriber Signature		Date
		2023 [Medicare Step Therapy Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document