

HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: 888-339-8351 • Fax: 844-525-6575



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	ender: O M O F Caregiver:	Office Cortiae	t:		
Height: We	ight: Allergies:	Specialty: 🛘	Cardiology Lip	idology 🛭 Othe	er
3 STATEMENT (OF MEDICAL NECESSITY: (Pleas	se Attach All Medica	l Documentation an	d Laboratory Re	sults)
Date of Diagnosis:			Prior	Indicate Dru	
Primary ICD-10: Secondary ICD-10:			Failed Therapies:	and Length of Treatment:	
Other:			☐ Fibrates		
Contraindications:			□ Niacin		
Fibrates: ☐ Yes ☐ No Statin: ☐ Yes ☐ No Niacin: ☐ Yes ☐ No			☐ Omega-3		
If yes: \square Myopathy or Rhabdomyolysis \square Hepatic Disease \square Renal Dysfunction			□ Statin		
□ Pregnancy or Lactation □ Recent Stroke or TIA □ Other			☐ Other		
Laboratory Tests:					
☐ Lipid Panel	□ No □ Yes Date:		If Prior Authorizat		
			I formulary alternate	tives will be brovi	
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