

**Community Care of North Carolina– <INSERT NETWORK NAME HERE>
MD Easy™ Form – Fibrates**

This form MUST BE FAXED to the PHARMACY

Practice Information		Patient Information	
Practice Name		Patient Name	
Practice Address		Patient Address	
Practice City, State, Zip		Patient City, State, Zip	
Practice Phone	Practice Fax	Date of Birth	Medicaid ID
Pharmacy Information		Originally Prescribed Fibrate	
Pharmacy Name		Drug Name/Strength	
Pharmacy Phone	Pharmacy Fax	Last Filled	Quantity

Fibrates Prior Authorization Criteria

Criteria:

1. Generic gemfibrozil will not require prior authorization.
2. Criteria for use of generic fenofibrate:
 - a. Documented failure with at least a 60-day trial of generic gemfibrozil within the last 12 months.
3. Criteria to use all other fibrates:
 - a. Documented failure with at least a 60-day trial of generic gemfibrozil and at least a 60-day trial of generic fenofibrate within the last 12 months.

Exemptions:

1. Documented contraindication to, allergy to, intolerable side effect from, or drug interaction with generic gemfibrozil or generic fenofibrate.
2. Patients who require Trilipix because they are on a statin medication are exempt from the criteria.
3. Patients who require Lovaza because they have high triglyceride levels (> 500mg/dl) are exempt from the criteria.

Please select the following option and fax to patient's pharmacy

****Attention Pharmacists****

*Please discontinue originally prescribed Fibrates listed above and change patient to the approved therapy below.
If the patient does not immediately need this prescription, please keep it on file for the next refill.*

Gemfibrozil 600 mg

Directions: _____

Dispense #: _____ Refill#: _____

Prescriber Signature: _____ Date: _____

Prescriber Name (please print): _____ DEA/NPI: _____

Note: By signing this document & checking the substitution above, you are consenting to this being a legal prescription & the pharmacy should fill it as such.