

Atorvastatin, Crestor, Vytorin PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____				
SECTION A - PATIENT INFORMATION				
First Name:		Last Name:		Member ID:
Address:				
City:		State:		Zip:
Phone:		DOB:		Allergies:
Primary Insurance:		Policy #:		Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/>? If so, start date: _____ Is this patient currently hospitalized? <input type="checkbox"/>Yes <input type="checkbox"/>No				
SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:		State: Zip:
Phone:		Fax:		NPI #: Specialty:
Office Contact Name / Fax Attention to:				
SECTION C - MEDICAL INFORMATION				
Medication:			Strength:	
Directions for use:				
Diagnosis (Please be specific & provide as much information as possible):				ICD-10 CODE:
Has the patient previously been treated with simvastatin at a dose of <u>40mg daily</u> for at least 90 days? Yes or No (Circle Answer) If yes, please provide dates of trial: _____				
Did treatment with simvastatin <u>40mg daily</u> for at least 90 days result in an inadequate response? Yes or No (Circle Answer) List date and results of lipid panel after simvastatin therapy: Date of Results: _____				
Has the patient experienced an intolerance/adverse reaction or a contraindication to previous therapy with simvastatin? Yes or No (Circle Answer) If yes, please describe adverse reaction or contraindication: _____				
Other Medications Tried				
Medication Name	Strength	Directions For Use	Dates of Trial	Reason for Discontinuation
Please provide any additional clinical information to support this request here: _____				

Physician Signature: _____ **Date:** _____

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