UnitedHealthcare Community Plan

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 ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐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 40mg daily for at least 90 days?
Yes or No (Circle Answer) If yes, please provide dates of trial:_____

Did treatment with simvastatin 40mg daily 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: _____