ZETIA

PRIOR AUTHORIZATION REQUEST FORM

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-9 CODE:**

- Is this a new prescription for the patient or a continuation of existing therapy?
- Has the patient previously been treated with one of the following statin drugs?
  List the medication(s), doses, and dates tried in the table below:
  Zocor (simvastatin)
  Pravachol (pravastatin)
  Mevacor (lovastatin)
  Lipitor (atorvastatin)
  Crestor (rosuvastatin)
  Lescol (fluvastatin)
  Livalo (pitavastatin)
- Did treatment with a statin result in an inadequate response?
  List date and results of lipid panel after statin therapy:
  Total Cholesterol: _____ (normal <200 mg/dl)
  HDL: _____ (normal >40 for men, >50 for women)
  LDL: _____ (normal <100 mg/dl)
  Triglycerides: _____ (normal <150 mg/dl)
- Has the patient experienced an intolerance/adverse reaction or a contraindication to previous therapy with statins? *List intolerance/adverse reaction/contraindication.*

Explanation of why the preferred medication(s) would not meet your patient's needs:

Other Medications tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ Date:_____