

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:
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- 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: _____

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