

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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