



Prior Authorization Form

Lipitor®/Caduet®/Vytorin®*/Crestor®*

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Lipitor® [] Caduet® [] Vytorin®* [] Crestor®* #
Date: Patient ID#: DOB:
Patient Name: Provider NPI:
Prescribing Physician: Office Contact:
Office Fax #: Office Phone:

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- 1. DIAGNOSIS FOR DRUG REQUESTED:
2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)
[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration

- 3. PATIENT HISTORY:
a. Has the patient tried and failed a Simvastatin containing product for a minimum of 30 days?
b. Has the patient tried and failed a Pravastatin containing product for a minimum of 30 days?
c. Has the patient tried and failed a Lovastatin containing product for a minimum of 30 days?
d. Has the patient tried and failed a rosuvastatin calcium (Crestor®) for a minimum of 30 days?
e. Does the patient have an intolerance/contraindication/allergy to Simvastatin, Pravastatin, Lovastatin containing product or Crestor®? (please specify in the supporting information section)

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document # Coverage effective date / /
Processor Initials Date
M F Rx coverage Y N STANDARD - SELECT LOB
Previous Auth Y N Approved Reviewer Initials Date

* CRESTOR AND VYTORIN DO NOT REQUIRE PRIOR AUTHORIZATION UNDER MEDICARE PART D