



Please complete ALL information below and fax your request to 1-888-671-5285

### Pravachol® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for <b>GENERIC</b> <input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>	Directions for Use:	

Clinical Information (required)
<b>Select the Type(s) of Coverage Determination Requested:</b> <input type="checkbox"/> <b>Non-Formulary</b> - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year. <input type="checkbox"/> <b>Step Therapy</b> - Request is for an exception to try another drug before the requested drug being prescribed. <input type="checkbox"/> <b>Quantity Limit</b> - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____
<b>Select the diagnosis below:</b> <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hypertriglyceridemia <input type="checkbox"/> Mixed dyslipidemia <input type="checkbox"/> Prevention of cardiovascular disease - myocardial infarction (MI), stroke/transient ischemic attack (TIA), revascularization procedures, cardiovascular mortality, slow the progression of coronary atherosclerosis <input type="checkbox"/> Primary dysbetalipoproteinemia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<b>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</b> <input type="checkbox"/> Atorvastatin <input type="checkbox"/> Livalo <input type="checkbox"/> Rosuvastatin <input type="checkbox"/> Fluvastatin <input type="checkbox"/> Lovastatin <input type="checkbox"/> Simvastatin <input type="checkbox"/> Fluvastatin extended-release (ER) <input type="checkbox"/> Pravastatin <input type="checkbox"/> Other drugs in the same class. Please specify: _____ <input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____
<b>Quantity limit requests:</b> Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

\_\_\_\_\_

Please note: This request may be denied unless all required information is received.

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