FUTURE SCRIPTS

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

Health Care Reform- $0 Statin Preventive (atorvastatin 10mg or 20mg & simvastatin 5mg, 10mg, 20mg or 40mg)

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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Clinical information*:

Is the patient at least 40 years old and younger than 75 years old? ❑ **Yes** ❑ **No**

Is the medication being used for primary prevention of cardiovascular disease (CVD) (i.e., patient has no history of cardiovascular events)? ❑ **Yes** ❑ **No**

Does the patient have one or more risk factors for CVD (i.e., dyslipidemia, diabetes, hypertension, or smoking)? ❑ **Yes** ❑ **No**

Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

***May not apply to all plans**

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.