FUTURE SCRIPTS

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

Crestor®, Lipitor®, Livalo®, Vytorin®, Zypitamag™
Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Coronary heart disease (CHD) – reduce risk for myocardial infarction (MI), stroke, revascularization procedures, hospitalization for congestive heart failure, and angina
- ❑ Diabetes mellitus type 2 – reduce risk of MI and stroke
- ❑ Homozygous Familial Hypercholesterolemia (HoFH)
- ❑ Hypercholesterolemia
- ❑ Hyperlipidemia
- ❑ Hypertriglyceridemia
- ❑ Mixed dyslipidemia
- ❑ Multiple risk factors for CHD – reduce risk of MI, stroke, revascularization procedures, and angina
- ❑ Primary dysbetalipoproteinemia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Select the medications the patient has had an inability to tolerate or has had an inadequate response to:

- ❑ Atorvastatin
- ❑ Pravastatin
- ❑ Rosuvastatin
- ❑ Simvastatin
- ❑ Other generic HMG CoA reductase inhibitor(s) not listed above. (Please specify all agents):_____
  _____

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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