AmeriHealth

# 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: _____

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**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."

| Drug Name | Date | Duration |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**3. PATIENT HISTORY:**

**a.** Has the patient tried and failed a Simvastatin containing product for a minimum of 30 days? ☐ Yes ☐ No

**b.** Has the patient tried and failed a Pravastatin containing product for a minimum of 30 days? ☐ Yes ☐ No

**c.** Has the patient tried and failed a Lovastatin containing product for a minimum of 30 days? ☐ Yes ☐ No

**d.** Has the patient tried and failed a rosuvastatin calcium (Crestor®#) for a minimum of 30 days? ☐ Yes ☐ No

**e.** Does the patient have an intolerance/contraindication/allergy to Simvastatin, Pravastatin, Lovastatin containing product or Crestor®#? (please specify in the supporting information section) ☐ Yes ☐ No

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** **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

**# CRESTOR DOES NOT APPLY TO MEDICARE PART D**

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



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