



Date _____

Client _____

PRIOR AUTH CRITERIA- Statins and Statin Combinations

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*

- Lipitor Vytorin
- Advicor Caduet

STEP C**

- Crestor Atoprev
- Lescol Lescol XL
- Other Brand Statin _____

***Please note that if member is beginning therapy with a statin, the member’s benefit will only cover a generic statin. Step B drugs will be approved only after member has tried/failed a 30-day supply of a generic statin, or if member needs > 50% LDL reduction to reach goal.**

****Please Note that Step C drugs will not be approved unless all appropriate Step B drugs have been tried/failed.**

2. Member’s LDL and date prior to statin therapy: _____

3. Member’s current LDL AND HDL levels and date taken: _____

- | | | |
|---|-----|----|
| 4. Does the member have atherosclerotic disease? | Yes | No |
| 5. Is there a family history of premature CHD? | Yes | No |
| 6. Does the member smoke? | Yes | No |
| 7. Does the member have hypertension? | Yes | No |
| 8. Is the member a man over 45 y/o, or a woman over 55 y/o? | Yes | No |
| 9. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of a generic statin? | Yes | No |
10. Please explain the reason for failure or non-trial, and attach notes from the patient’s chart as documentation.

11. Does the patient have liver disease or elevated LFT’s? Yes No

12. Is the patient pregnant or nursing? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com