



**Independence
Blue Cross**

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**