EXPRESS SCRIPTS®

Prior Authorization Form
HMG Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Altoprev 20mg
- ☐ Altoprev 40mg
- ☐ Altoprev 60mg
- ☐ Caduet 2.5mg-10mg
- ☐ Caduet 2.5mg-20mg
- ☐ Caduet 2.5mg-40mg
- ☐ Caduet 5mg-10mg
- ☐ Caduet 5mg-20mg
- ☐ Caduet 5mg-40mg
- ☐ Caduet 5mg-80mg
- ☐ Caduet 10mg-10mg
- ☐ Caduet 10mg-20mg
- ☐ Caduet 10mg-40mg
- ☐ Caduet 10mg-80mg
- ☐ Crestor 5mg
- ☐ Crestor 10mg
- ☐ Crestor 20mg
- ☐ Crestor 40mg
- ☐ Lipitor 10mg
- ☐ Lipitor 20mg
- ☐ Lipitor 40mg
- ☐ Lipitor 80mg
- ☐ Lescol 20mg
- ☐ Lescol 40mg
- ☐ Lescol XL 80mg Extended-Release Tab
- ☐ Livalo 1mg
- ☐ Livalo 2mg
- ☐ Livalo 4mg
- ☐ Mevacor 20mg
- ☐ Mevacor 40mg
- ☐ Pravachol 20mg
- ☐ Pravachol 40mg
- ☐ Pravachol 80mg
- ☐ Vytorin 10mg-10mg
- ☐ Vytorin 10mg-20mg
- ☐ Vytorin 10mg-40mg
- ☐ Vytorin 10mg-80mg
- ☐ Zocor 5mg
- ☐ Zocor 10mg
- ☐ Zocor 20mg
- ☐ Zocor 40mg
- ☐ Zocor 80mg

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication?	☐ Yes	☐ No	☐ N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No	☐ N/A

3. Has the patient tried any of the following?	☐ Yes	☐ No	
☐ Crestor ☐ Lipitor (Brand) ☐ Vytorin ☐ Mevacor (Brand) ☐ Pravachol (Brand) ☐ Zocor (Brand) ☐ Caduet (Brand) ☐ atorvastatin (generic) ☐ lovastatin (generic) ☐ pravastatin (generic) ☐ simvastatin (generic) ☐ fluvastatin (generic) ☐ amlodipine/atorvastatin (generic) ☐ Other: _____ If no, please explain: _____ _____			

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.