EXPRESS SCRIPTS®

Prior Authorization Form
Zetia 10mg 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: _____

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

Please complete the clinical assessment:		
1. Is the patient currently taking the requested medication? If yes, for how long? _____	☐ Yes	☐ No
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
3. Is the patient taking a medication that has a significant drug interaction potential with the HMG-CoA reductase inhibitors? If yes, please explain: _____	☐ Yes	☐ No
4. Has the patient been previously diagnosed with myopathy or rhabdomyolysis (either medication-related or not medication related)?	☐ Yes	☐ No
5. Does the patient have an underlying muscle/muscle-metabolism-related disorder (for example, myositis, McArdle disease)? If yes, please explain: _____	☐ Yes	☐ No

6. Does the patient meet one of the following conditions:

☐ Yes (please indicate) ☐ No

- ☐ Active liver disease or unexplained persistent elevations of serum transaminases
- ☐ Homozygous familial sitosterolemia
- ☐ Pregnancy
- ☐ Severe renal impairment (creatinine clearance less than or equal to 30ml/min)

7. Has the patient tried one HMG-CoA reductase inhibitor (may be brand or generic) or HMG-CoA reductase inhibitor combination product or is Zetia being started in combination with an HMG-CoA reductase inhibitor?

☐ Yes (please indicate) ☐ No

- ☐ Advicor
- ☐ Altoprev
- ☐ Caduet
- ☐ Crestor
- ☐ Juvisync
- ☐ Lescol
- ☐ Lescol XL
- ☐ Lipitor
- ☐ Livalo
- ☐ Lovastatin
- ☐ Mevacor
- ☐ Pravachol
- ☐ Pravastatin
- ☐ Simcor
- ☐ Simvastatin
- ☐ Vytorin
- ☐ Zocor
- ☐ Other: _____

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.