



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Rosuvastatin Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information <small>(required)</small> | | | |
|---|--|---------------------|--------------|
| Medication Name: | | Strength: | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | |

| Clinical Information <small>(required)</small> |
|---|
| <p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <hr style="border: 0.5px solid black;"/> <hr style="border: 0.5px solid black;"/> |

| |
|--|
| <p>Select the diagnosis below:</p> <p><input type="checkbox"/> Homozygous familial hypercholesterolemia</p> <p><input type="checkbox"/> Hypertriglyceridemia</p> <p><input type="checkbox"/> Mixed dyslipidemia</p> <p><input type="checkbox"/> Primary dysbetalipoproteinemia (Type III Hyperlipoproteinemia)</p> <p><input type="checkbox"/> Primary hyperlipidemia</p> <p><input type="checkbox"/> Primary prevention of cardiovascular disease</p> <p><input type="checkbox"/> Slowing of the progression of atherosclerosis</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p> |
|--|

| |
|---|
| <p>Medication history: Has the patient had prior use of atorvastatin or is atorvastatin contraindicated, inappropriate, or ineffective for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|

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

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-855-297-2870.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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Office use only: Rosuvastatin_GoldCoast_2018Sep-W