



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

Simvastatin 80mg tablet Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
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 (required)		
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 (required)
<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/>

<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Adolescent patients with Heterozygous Familial Hypercholesterolemia (HeFH)</p> <p><input type="checkbox"/> Hyperlipidemia</p> <p><input type="checkbox"/> Reductions in risk of coronary heart disease (CHD) mortality and cardiovascular events</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p>Clinical information:</p> <p>Has the patient been taking simvastatin 80mg previously with no evidence of muscle toxicity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there presence of contraindications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is simvastatin 80mg co-administered with a CYP 3A4 inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the patient previously tolerating a lower dose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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 Office use only: Simvastatin80mgtablet_GoldCoast_2017Sep-W