**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: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Continuation of therapy:**

Is this a continuation of prior therapy? ❑ **Yes** ❑ **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)**

_____

_____

**Select the diagnosis below:**

❑ Adolescent patients with Heterozygous Familial Hypercholesterolemia (HeFH)
❑ Hyperlipidemia
❑ Reductions in risk of coronary heart disease (CHD) mortality and cardiovascular events
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical information:**

Has the patient been taking simvastatin 80mg previously with no evidence of muscle toxicity? ❑ **Yes** ❑ **No**
Is there presence of contraindications? ❑ **Yes** ❑ **No**
Is simvastatin 80mg co-administered with a CYP 3A4 inhibitor? ❑ **Yes** ❑ **No**
Was the patient previously tolerating a lower dose? ❑ **Yes** ❑ **No**

**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.