



Attention: ACTION REQUESTED
 Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: Simvastatin

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria:

- Covered Uses:** All medically accepted indications not otherwise excluded from Part D.
- Required Medical Information:** For continuation of therapy with simvastatin 80 mg per day and no evidence of myopathy (eg, muscle pain, muscle tenderness, muscle weakness) on simvastatin 80 mg per day.
- Coverage Duration:** 12 months

Member Information		Prescriber Information	
Patient Name:	Prescriber Name:		
Member ID#	NPI or DEA#:		
DOB:	Office Phone:	Office Fax:	
Address:	Address:		
Home Phone:	Contact Person:		
Medication Information		Medical Information	
Medication Requested (drug name, strength and route of administration):	Drug Allergies:		
Medication Details (frequency, quantity):	Diagnosis:		
Expected Length of Therapy:	Prescriber's Signature/Date:		

New Prescription OR Date Therapy Initiated:

Rationale for Prior Authorization

1. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Additional comments: _____

3. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
 Our Formulary List is located at <http://www.qualityhealthplansny.com>

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