# Network Health
# HMG-CoA Reductase Inhibitors Prior Authorization Request

**Medication Request Form (MRF)**
**FAX TO: (877) 501-1059**
**c/o MedImpact Healthcare Systems, Inc.**
Attn: Prior Authorization Department
10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

**Crestor, Lescol, Lescol XL, Lipitor, Zocor Brand Name, Pravachol Brand Name, Mevacor Brand Name**

**Instructions:**
This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to Med**Impact** Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact Med**Impact**'s Customer Service at (800) 788-2949.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

**Member/Provider Information:**

| | |
|---|---|
| **Member's Name:** | **Prescriber's Name:** |
| **Member's Network Health ID #:** | **Prescriber's Specialty:** |
| **Member's DOB** (mm-dd-yy)**:** | **DEA # (Required):** _____<br>**NPI #:** _____ |
| **Pharmacy used by Member:** | **Prescriber's Telephone Number/Contact Name:** |
| **Pharmacy (Area Code) Telephone Number:** | **Prescriber's (Area Code) Fax Number:** |

**Clinical Information:**

****Note: The generic statins, lovastatin, pravastatin, and simvastatin are Network Health's first line therapies and do not require prior authorization. Requested Drug:**

☐ Crestor ☐ Lescol ☐ Lescol XL ☐ Lipitor

☐ Mevacor Brand Name ☐ Pravachol Brand Name ☐ Zocor Brand Name

**Diagnosis:**

**Dose and Quantity Requested:**

**Documentation of Medical Necessity** (please check all that apply):

1. Please indicate if the patient has had previous trials with generic agents or if the agent is contraindicated (check all that apply, circle the strength, then provide reason for discontinuation or contraindication):

**Reason for discontinuation or contraindication:**

☐ lovastatin 10mg 20mg 40mg _____
☐ pravastatin 10mg 20mg 40mg 80mg _____
☐ simvastatin 5mg 10mg 20mg 40mg 80mg _____ _____

2. Is the desired response in this patient unachievable with the preferred generic statin (lovastatin, pravastatin or simvastatin) ?
   ☐ Yes ☐ No
3. For BRAND NAME Requests: Justification why generic cannot be used _____
   _____

☐ **Request for expedited review (72 hours):** By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

**SIGNATURE:** I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's Signature (STAMP NOT ACCEPTED) Date

| DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY |
|---|
| Contacted: |
| Provider: |
| Pharmacy: |
| Patient: |

| DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY |
|---|
| Approved: |
| Denied: |
| Returned: |
| PA # |