

OPTIMA HEALTH PLAN

Pharmacy Prior Authorization Request Form*

Directions: *The prescribing physician must sign and clearly print name. (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Name: Crestor (rosuvastatin)

- Simvastatin has demonstrated proven outcomes in decreasing morbidity and mortality in large number of patients over many years in peer-reviewed published clinical trials.
- According to published data for Simvastatin 40 mg daily, the lipid lowering effect is comparable to any other agent on the market.
- Patients titrated to Simvastatin 40 mg should receive an additional liver function test at 3 months.

Please indicate below reason for request:

___ Patient failed to reach LDL-cholesterol goals with a trial of Simvastatin 40 mg for at least 30 days.

___ Patient had an adverse reaction(s) to Simvastatin. Please list reaction(s):

___ Patient initiated therapy with Crestor while covered under another insurance plan and recently converted to Sentara/Optima coverage (subject to verification by Sentara/Optima).
Please note: Use of samples to initiate therapy does not meet preauthorization criteria.

Patient _____

Member Number _____

Signed _____ Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____

(If available)

*Approved by Pharmacy and Therapeutics Committee on 07/19/2007