

# 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: Caduet (amlodipine/atorvastatin)

- According to published data for Crestor, the lipid lowering effect is comparable to any other agent on the market.
- Several peer-reviewed clinical trials have recognized that Crestor was more effective in reducing LDL cholesterol levels in patients who have trouble meeting their targets for risk reductions.
- Patients titrated on Crestor therapy should receive an additional liver function test at 3 months.

### Please indicate below reason for request:

*(Crestor also requires prior authorization)*

\_\_\_ Patient failed to reach LDL-cholesterol goals with a trial of Crestor for at least 30 days.

\_\_\_ Patient had an adverse reaction(s) to Crestor. Please list reaction(s):  
\_\_\_\_\_

\_\_\_ Patient initiated therapy with Lipitor, Vytorin, or Lescol 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