



Non-Preferred Statin Request Form Fee-for-Service Medicaid/PeachCare for Kids

FAX: 1-888-491-9742
PHONE: 1-866-525-5827

TODAY'S DATE: _____

Note: If the following information is NOT filled in completely, correctly, and/or legibly the appeal process **will** be delayed. **(One form per Member please)**

MEMBER Last Name [Grid]	MEMBER First Name [Grid]
MEMBER ID number [Grid]	MEMBER Date of Birth [Grid]
PRESCRIBER Last Name [Grid]	PRESCRIBER First Name [Grid]
PRESCRIBER NPI# [Grid]	
PRESCRIBER Phone [Grid]	PRESCRIBER Fax [Grid]
PRESCRIBER Address [Grid]	

Medication Requested: _____ **Strength** _____ **Directions --** _____

A COPY OF THE MEMBER'S LIPID PANELS MUST BE INCLUDED WHEN SUBMITTING
(both Pre-Treatment LDL Value/Date and Current LDL Value/Date are required to complete the review)

Diagnoses	Yes	No	Unknown
Coronary Heart Disease (CHD)			
Diabetes Mellitus			
Carotid Artery Disease			
Peripheral Arterial Disease			
Abdominal Aortic Aneurysm			
Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)			
Risk Factors	Yes	No	Unknown
Age: M >45yrs, F >55yrs			
Hypertension (≥130/≥85 mmHg or on HTN medication)			
HDL cholesterol: M <40 mg/dL, F <50 mg/dL			
Family history of premature CHD in first degree relative: M <55yrs, F <65yrs			
Cigarette smoking			
Metabolic Syndrome			
Yes No Unknown			
Abdominal obesity (waist circumference: M >40in, F >35in)			
Triglycerides ≥150 mg/dL			
HDL: M <40 mg/dL, F <50 mg/dL			
BP ≥130/≥85 mmHg			
Fasting glucose ≥110 mg/dL			

Please check box if you are attaching page 2 with this request.

Physician Signature (Required) _____

