GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Non-Preferred Statin Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, and/or legibly the appeal process **will** be delayed.
Please complete one form for each member.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

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)

Select the diagnosis below:
- ❑ Abdominal Aortic Aneurysm
- ❑ Carotid Artery Disease
- ❑ Coronary Heart Disease (CHD)
- ❑ Diabetes Mellitus
- ❑ Peripheral Arterial Disease
- ❑ Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)
- ❑ Other diagnosis: ____

Clinical information:
Select if the member has any of the following risk factors:
- ❑ Age: Male (M) >45yrs, Female (F) >55yrs
- ❑ Cigarette smoking
- ❑ Family history of premature CHD in first degree relative: M <55yrs, F <65yrs
- ❑ HDL cholesterol: M <40 mg/dL, F <50 mg/dL
- ❑ Hypertension (≥130/≥85 mmHg or on HTN medication)
- ❑ Metabolic Syndrome

If the member has metabolic syndrome, select all applicable risk factors below:
- ❑ Abdominal obesity (waist circumference: M >40in, F >35in)
- ❑ BP ≥130/≥85 mmHg
- ❑ Fasting glucose ≥110 mg/dL
- ❑ HDL: M <40 mg/dL, F <50 mg/dL
- ❑ Triglycerides ≥150 mg/dL

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Non-Preferred Statin Prior Authorization Request Form

In the space below, please provide any further information certifying medical necessity for your patient to remain on current therapy.

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Physician Signature (required): ________________________________ **Date**:______________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.

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