JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Is the request for Vytorin 10/10 or 10/20?** | ☐ Yes<br>Proceed to Question 2 | ☐ No<br>**Skip** to Question **3** |
| **2.** *[Request is for Vytorin 10/10 or 10/20]*<br>**Does the patient require an LDL cholesterol decrease of 30% to 50% from the pre-treatment LDL level?**<br>*(Moderate intensity)* | ☐ Yes<br>**Skip** to Question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3.** *[Request is for Vytorin 10/40 or 10/80]*<br>**Does the patient require an LDL cholesterol decrease of more than 50% from the pre-treatment LDL level?**<br>*(High intensity)* | ☐ Yes<br>**Skip** to Question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Has the patient tried atorvastatin** (Lipitor) **OR rosuvastatin** (Crestor) **and was unable to tolerate treatment due to adverse effects?** | ☐ Yes<br>Sign and date on page 2 | ☐ No<br>**Skip** to Question **7** |
| **5. Has the patient tried atorvastatin** (Lipitor) **at a dose of 40 mg or higher and was unable to tolerate treatment due to adverse effects?** | ☐ Yes<br>Sign and date on page 2 | ☐ No<br>Proceed to Question 6 |
| **6. Has the patient tried rosuvastatin** (Crestor) **at a dose of 20 mg or higher and was unable to tolerate treatment due to adverse effects?** | ☐ Yes<br>Sign and date on page 2 | ☐ No<br>Proceed to Question 7 |

*Continue on next page*

Prior Authorization Request Form for
simvastatin-ezetimibe **(Vytorin**)

| | | |
|---|---|---|
| **7. Is the patient receiving ezetimibe** (Zetia) **and simvastatin** (Zocor) **as 2 separate pills?** | ☐ Yes<br>Proceed to Question 8 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Does the patient have swallowing difficulties thereby requiring the use of the fixed-dose combination?** | ☐ Yes<br>Sign and date below | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

**I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[ 10 May 2017 ]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |