OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

HCR Statins (atorvastatin 10mg or 20mg & simvastatin 5mg, 10mg, 20mg or 40mg) Zero Copay Request

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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)

Clinical information*:

Is the patient at least 40 years old and younger than 75 years old? ❑ **Yes** ❑ **No**

Is the requested medication being used for primary prevention of cardiovascular disease (CVD) (i.e., patient has no history of cardiovascular events)? ❑ **Yes** ❑ **No**

Does the patient have one or more risk factors for CVD (i.e., dyslipidemia, diabetes, hypertension, or smoking)? ❑ **Yes** ❑ **No**

Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _______
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

*May not apply to all plans

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

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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