Altoprev®, Lescol® (fluvastatin), and Lescol XL® (fluvastatin extended-release [ER])

Prior Authorization Request Form

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

Member Information (required)  Provider Information (required)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance ID#:</td>
<td>NPI#:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Specialty:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>City:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>State:</td>
<td>Office Street Address:</td>
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<tr>
<td>Zip:</td>
<td>City:</td>
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<tr>
<td>Phone:</td>
<td>State:</td>
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<tr>
<td></td>
<td>Zip:</td>
</tr>
</tbody>
</table>

Medication Information (required)

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dosage Form:</td>
</tr>
</tbody>
</table>

- Check if requesting brand
- Check if request is for continuation of therapy

Clinical Information (required)

Select the diagnosis below:

- Coronary heart disease (CHD) [Altoprev only]
- Hypercholesterolemia
- Hyperlipidemia [Altoprev only]
- Mixed dyslipidemia (Frederickson types IIa and IIb)
- To prevent cardiovascular disease in patients with CHD [Lescol (fluvastatin) and Lescol XL (fluvastatin ER) only]
- To prevent CHD in patients at high risk [Altoprev only]
- Other diagnosis: ______________________________

ICD-10 Code(s): ______________________________

Select the medications the patient has a failure, contraindication, or intolerance to:

- Atorvastatin
- Ezetimibe-simvastatin
- Floliopid
- Fluvastatin
- Fluvastatin ER
- Livalo
- Lovastatin
- Pravachol
- Pravastatin
- Rosuvastatin
- Simvastatin
- Zocor

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
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: ______________________________
- Other: ______________________________

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.