AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid)</u> on this request. All other information may be filled in by office staff; <u>fax to 1-800-750-9692</u>. No additional phone calls will be necessary if all information (<u>including phone and fax #s</u>) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

Drug Requested: ACA Copay Waiver for High dose Statins

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.			
Mei	ember Name:		
	ember AvMed #:		
Pre	escriber Name:		
Pre	escriber Signature:	Date:	
Off	fice Contact Name:		
		Fax Number:	
	RUG INFORMATION: Authorization 1		
Dru	ug Form/Strength:		
Dos	sing Schedule:	Length of Therapy:	
Dia	ngnosis:	ICD Code, if applicable:	
We	eight:		
suj		that apply. All criteria must be met for approval. To acluding lab results, diagnostics, and/or chart notes, must be	
Cov	verage at zero-dollar cost share will be app	roved based on ALL the following criteria:	
	Member is ≥ 40 years to ≤ 75 years of age		
	Requested medication and dose has been pre	scribed for primary prevention of cardiovascular disease (CVD)	
	☐ Member does <u>NOT</u> have a history of (or signs or symptoms of) CVD (e.g., symptomatic coronary artery disease, ischemic stroke)		
	Member has at least <u>ONE</u> of the following O ☐ Dyslipidemia ☐ Diabetes ☐ Hypertension ☐ Member is a smoker	CVD risk factors:	
	Member has an estimated 10-year CVD ever	nt risk of 10% or greater	
	Prescriber attests requested medication and dose is medically necessary		