



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.
P.O. Box 98031 • Baton Rouge, Louisiana • 70898-9031



**CONFIDENTIAL
PATIENT INFORMATION**

**DRUG AUTHORIZATION FORM
HMG-CoA Reductase
Inhibitor Agents and Combos**

Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number		Area of Practice/Specialty		Phone Number ()	

REQUESTED DRUG*

<input type="checkbox"/> Advicor® <input type="checkbox"/> Altoprev® <input type="checkbox"/> Caduet® <input type="checkbox"/> Crestor® 5 mg <input type="checkbox"/> Lescol® <input type="checkbox"/> Lescol® XL <input type="checkbox"/> Lipitor®	<input type="checkbox"/> Livalo® <input type="checkbox"/> Mevacor® <input type="checkbox"/> Pravachol® <input type="checkbox"/> Simcor® <input type="checkbox"/> Vytorin® <input type="checkbox"/> Zocor® <input type="checkbox"/> Other _____
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PAST TREATMENT HISTORY (Check ALL that apply)

<input type="checkbox"/> Altoprev® <input type="checkbox"/> Atorvastatin® <input type="checkbox"/> Atorvastatin®/Amlodipine® <input type="checkbox"/> Crestor® <input type="checkbox"/> Lipitor® <input type="checkbox"/> Lescol® <input type="checkbox"/> Lescol® XL <input type="checkbox"/> Lovastatin <input type="checkbox"/> Mevacor® <input type="checkbox"/> Pravachol® <input type="checkbox"/> Pravastatin <input type="checkbox"/> Simvastatin <input type="checkbox"/> Vytorin® <input type="checkbox"/> Zocor® <input type="checkbox"/> Other _____
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PHYSICIAN SIGNATURE	DATE
Prescribing Physician _____	_____

*Preferred brand drugs (Tier 2) are designated in bold.
Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed