# STATIN STEP THERAPY
## PHYSICIAN FAX FORM

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**ONLY the prescriber or clinic personnel may complete this form.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross Blue Shield of North Dakota web site at **www.bcbsnd.com.**

**Today's Date:** _____

**PATIENT INFORMATION**

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|
| Patient Address: | City, State, Zip | Patient Telephone: | |

**INSURANCE INFORMATION**

| BCBS ID Number: | Group Number: |
|---|---|

**PHYSICIAN/CLINIC INFORMATION**

| Prescriber Name: | Physician NPI#: | Specialty: | Contact Name: |
|---|---|---|---|
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

| Patient's Diagnosis - ICD-9 code plus description: | |
|---|---|
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |

1. Patient's baseline (pretreatment) fasting lipid panel:
   Total Cholesterol _____ Triglycerides _____ HDL _____ LDL _____
2. Patient's goal LDL _____ OR goal % LDL reduction _____
3. Does the patient's medical history include any of the following:
   Coronary Atherosclerosis ..... ☐ Yes ☐ No
   Diabetes ..... ☐ Yes ☐ No
   Congestive Heart Failure ..... ☐ Yes ☐ No
   Other (please explain):_____
4. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____
   _____
5. Please list all other medications the patient is **currently taking for treatment of this diagnosis.** _____
   _____
6. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____
   _____

**Please fax or mail this form to:**
Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130**

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