

Statin Medications Available without a Prior Authorization

Patient's Name:

Patient's DOB:

Date:

This patient's prescription for _____ has been changed to the following:

	Product Name	Size	Dosing
<input type="checkbox"/>	Simvastatin (Zocor)	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg	Take one tablet by mouth daily at bedtime.
<input type="checkbox"/>	Pravastatin (Pravachol)	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg	Take one tablet by mouth daily at bedtime.
<input type="checkbox"/>	Fluvastatin (Lescol XL)	<input type="checkbox"/> 80mg	Take one tablet by mouth daily at bedtime.
<input type="checkbox"/>	Fluvastatin (Lescol)	<input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take one tablet by mouth daily at bedtime. <input type="checkbox"/> Take one tablet by mouth twice daily.
<input type="checkbox"/>	Lovastatin (Mevacor)	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Take one tablet by mouth daily at bedtime.

Prescriber's Signature _____ **Date:** _____

Prescriber's Phone: _____

Please Send To

Pharmacy Name:

Pharmacy Fax:

Pharmacist, please place prescription in patient's file to be used for the next statin refill. Thank you.