



**Phone:** 330-363-6360  
**Fax:** 330-363-3284

Statin Preventive Medications  
 Enrollment Form



ADMINISTRATIVE GROUP

**PATIENT INFORMATION**

Patient Name		<input type="checkbox"/> Female <input type="checkbox"/> Male	Allergies	<input type="checkbox"/> NKDA
Date of Birth	SSN#	Weight _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Date		
Address		City	State	
Phone # (Home)	(Work)	Email address (optional)		

**INSURANCE INFORMATION**

Primary Insurance		Policyholder
Group #	Policy #	

**Service Is:**  Routine/Non-Urgent  Expedited/Urgent\*

\*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside this definition should be submitted as routine/non-urgent.

**MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS)**

Diagnosis: \_\_\_\_\_ ICD-10 code: \_\_\_\_\_

Does the patient have a history of cardiovascular disease?  yes  no

Does the patient have one or more of the following cardiovascular risk factors?  yes  no (please indicate)

Dyslipidemia  Diabetes  Hypertension  Smoking  Other: \_\_\_\_\_

Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater:  yes  no

**PRESCRIPTION INFORMATION**

Medication	Dose	Directions	Quantity
<input type="checkbox"/> Atorvastatin	<input type="checkbox"/> 10mg tablets <input type="checkbox"/> 20mg tablets	_____	# _____
<input type="checkbox"/> Fluvastatin	<input type="checkbox"/> 20mg tablets <input type="checkbox"/> 40mg tablets	_____	# _____
<input type="checkbox"/> Fluvastatin XL	<input type="checkbox"/> 80mg tablets	_____	# _____



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<input type="checkbox"/> Lovastatin	<input type="checkbox"/> 10mg tablets <input type="checkbox"/> 20mg tablets <input type="checkbox"/> 40mg tablets	<hr/>	# _____
<input type="checkbox"/> Pravastatin	<input type="checkbox"/> 10mg tablets <input type="checkbox"/> 20mg tablets <input type="checkbox"/> 40mg tablets <input type="checkbox"/> 80mg tablets	<hr/>	# _____
<input type="checkbox"/> Rosuvastatin	<input type="checkbox"/> 5mg tablets <input type="checkbox"/> 10mg tablets	<hr/>	# _____
<input type="checkbox"/> Simvastatin	<input type="checkbox"/> 5mg tablets <input type="checkbox"/> 10mg tablets <input type="checkbox"/> 20mg tablets <input type="checkbox"/> 40mg tablets	<hr/>	# _____

**PHYSICIAN CONTACT INFORMATION & AUTHORIZATION**

Physician Name	Office Contact
Phone	Fax
Address	City/State/Zip

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_