AULTCARE AULTRA

STATIN PREVENTIVE MEDICATIONS ENROLLMENT FORM

PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	☐ NKDA
Date of Birth	SSN#	Weight ☐ lb ☐ kg	Date
Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Email Address	

INSURANCE INFORMATION

Primary Insurance	Policy Holder
Group Number	Policy Number

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.

DIAGNOSIS AND HEALTH HISTORY

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

☐ 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
☐ Atrovastatin	☐ 10 mg tablets ☐ 20 mg tablets		
☐ Fluvastatin	☐ 20 mg tablets ☐ 40 mg tablets		

PRESCRIPTION INFORMATION			
Medication	**Dose**	**Directions**	**Quantity**
☐ Fluvastatin XL	☐ 80 mg tablets		
☐ Lovastain	☐ 10 mg tablets ☐ 20 mg tablets ☐ 40 mg tablets		
☐ Pravastatin	☐ 10 mg tablets ☐ 20 mg tablets ☐ 40 mg tablets ☐ 80 mg tablets		
☐ Rosuvastatin	☐ 5 mg tablets ☐ 10 mg tablets		
☐ Simvastatin	☐ 5 mg tablets ☐ 10 mg tablets ☐ 20 mg tablets ☐ 40 mg tablets		

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	Office Contact		
Phone Number	Fax Number		
Address	City	State	Zip Code
Physician Signature		Date	

Please submit form via fax at 330-363-3284