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
☐	**Simvastatin (Zocor)**	☐ 5mg ☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg	Take one tablet by mouth daily at bedtime.
☐	**Pravastatin (Pravachol)**	☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg	Take one tablet by mouth daily at bedtime.
☐	**Fluvastatin (Lescol XL)**	☐ 80mg	Take one tablet by mouth daily at bedtime.
☐	**Fluvastatin (Lescol)**	☐ 20mg ☐ 40mg	☐ Take one tablet by mouth daily at bedtime. ☐ Take one tablet by mouth twice daily.
☐	**Lovastatin (Mevacor)**	☐ 10mg ☐ 20mg ☐ 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.