



To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:
Medication:	Diagnosis:

**SECTION A**

Please answer the following questions

1.     Yes     No    Does the patient have a diagnosis of primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH) or are they at an increased risk for major adverse cardiovascular events?
  
2.     Yes     No    Has the member tried at least one high-intensity statin (for example, but not limited to atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) for 8 weeks or longer?
  
3.     Yes     No    Is the member statin intolerant as demonstrated by 1) experiencing statin-associated rhabdomyolysis at one statin OR 2) experiencing skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation?

