

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: ezetimibe-simvastatin (Vytorin®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage: 1 tablet once daily in the evening

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member has tried and failed **TWO** of the following high intensity statins, or statin therapy at maximally tolerated dose for at least 12 consecutive weeks and did **NOT** achieve LDL cholesterol goal (**verified by chart notes or pharmacy paid claims; check all that apply**)

<u>High-intensity</u>	<u>Moderate-intensity</u>	<u>Low-intensity</u>
<input type="checkbox"/> atorvastatin 40-80 mg	<input type="checkbox"/> atorvastatin 10-20 mg	<input type="checkbox"/> simvastatin 10 mg
<input type="checkbox"/> rosuvastatin 20-40 mg	<input type="checkbox"/> rosuvastatin 5-10 mg	<input type="checkbox"/> pravastatin 10-20 mg
	<input type="checkbox"/> simvastatin 20-40 mg	<input type="checkbox"/> lovastatin 20 mg
	<input type="checkbox"/> pravastatin 40-80 mg	<input type="checkbox"/> fluvastatin 20-40 mg
	<input type="checkbox"/> fluvastatin 40 mg BID	

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- ❑ Provider has submitted the results of member's lipid panel showing further reduction in LDL cholesterol is required despite compliant use of maximally tolerated statin monotherapy

Current LDL-C: _____ **LDL-C Goal:** _____

- ❑ Member has tried and had an inadequate response with a statin therapy (such as simvastatin) and ezetimibe used at the same time
- ❑ Provider has submitted chart notes to document the clinical rationale for why requested combination agent is medically necessary and not only for convenience

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****