# OPTIMA HEALTH PLAN

## 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 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

**Drug Requested: ezetimibe/simvastatin** (Vytorin®)

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

**Dosing Schedule:** _____ **Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**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)**

| High-intensity | Moderate-intensity | Low-intensity |
|---|---|---|
| ❑ atorvastatin 40-80 mg | ❑ atorvastatin 10-20 mg | ❑ simvastatin 10 mg |
| ❑ rosuvastatin 20-40 mg | ❑ rosuvastatin 5-10 mg | ❑ pravastatin 10-20 mg |
| | ❑ simvastatin 20-40 mg | ❑ lovastatin 20 mg |
| | ❑ pravastatin 40-80 mg | ❑ fluvastatin 20-40 mg |
| | ❑ fluvastatin 40 mg BID | |

- ❑ 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 adequate 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

**(Continued on next page; signature page is required to process request.)**

**(Please ensure signature page is attached to form.)**

*****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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***Approved by Pharmacy and Therapeutics Committee**: 5/19/2022
**REVISED/UPDATED:** ~~4/26/2022; 6/4/2022;~~ **6/17/2022**