SENTARA HEALTH PLANS

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 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 Sentara #: ______________________ **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)**

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	

(Continued on next page)

- ❑ 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.****

***Approved by Pharmacy and Therapeutics Committee**: **5/19/2022**
REVISED/UPDATED/REFORMATTED: ~~4/26/2022; 6/4/2022; 6/17/2022;~~ **1/22/2026**