PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

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Generic Statin Medications for Prevention Benefit Coverage with Waived Cost Share (atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, and simvastatin)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

Criteria:

See "Generic Statin Medications Chart" in "Definitions" section for dosing and age limitations based on USPSTF recommendations.

- **Criteria for initial therapy:** An exception request for USPSTF recommendation for generic statin medications atorvastatin, fluvastatin, fluvastatin ER, lovastatin, pravastatin, rosuvastatin, **OR** simvastatin for Prevention Benefit Coverage with Waived Cost Share is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual is 40 to 75 years of age

  2. Medical record documentation of **NO** history of cardiovascular disease (CVD) (symptomatic coronary artery disease or ischemic stroke).

  3. Medical record documentation of **ONE** of the following CVD risk factors:
     - Dyslipidemia
     - Diabetes
     - Hypertension
     - Smoking

  4. Has a calculated 10-year risk of a cardiovascular event of 10% or greater using the American Heart Association, American College of Cardiology ASCVD risk estimator (See http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/)

  5. There are no benefit or contract exclusions that apply

  Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request):** atorvastatin, fluvastatin, fluvastatin ER, lovastatin, pravastatin, rosuvastatin, OR simvastatin is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. The individual has benefited from therapy but remains at high risk

  2. The condition has not progressed or worsened while on therapy

  3. Individual has been adherent with the medication

  4. Individual has not developed any contraindications or other exclusions to its continued use

  5. There are no significant interacting drugs

  Renewal duration: 12 months

Description:

For certain benefit plans, certain generic statin medications when prescribed for prevention, may be available at zero member cost-share when dispensed through an in-network pharmacy. The zero member cost-share may only apply when prior authorization is approved. Medication coverage is subject to limitations, including but not limited to medications that are used preventatively but do not qualify for waive member cost share through the prevention benefits.

The Patient Protection and Affordable Care Act (PPACA) requires that non-grandfathered group and individual health plans waive cost share for in-network preventive services, including certain preventive medications and devices in certain circumstances when these are a current published recommendation Grade A or B by the United States Preventive Services Task Force (USPSTF). This benefit option does not apply universally to grandfathered plans. The cost share waiver does not apply when an out of network or non-contracted pharmacy provider is used. Second, there are some medications and devices that can be used for both preventive care and to treat a medical condition. Cost share is waived only when the medication or device is prescribed for preventive care. Some medications covered under prevention also have prescription limitations or precertification requirements. The medication must be prescribed for a preventive care purpose.

Providers may submit an exception request when medication is used for prevention but the claim is not processing under the prescription prevention benefit. However, a request is not a guarantee of coverage. Applicable benefit limitations and exclusions of the member's specific benefit plan may apply.

Definitions:

Guidance Regarding Preventive Medications as defined by the plan:
Click here for a current listing of preventive medications or go to www.azblue.com/pharmacy, view resources for Standard Pharmacy Plans, and select Guidance Regarding Preventive Medications under the Other Forms and Resources section.

FDA:
Food and Drug Administration

Medication Product Labeling:
Manufacturer FDA approved product information

U.S. Preventive Services Task Force (USPSTF):
An independent group of national experts in prevention and evidence-based medicine that makes recommendations about clinical preventive services such as screenings, counseling services, and preventive medication.

American College of Cardiology: ASCVD Risk Estimator: **http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/**
10-year risk for ASCVD:

Generic Statin Medications for Prevention Benefit Coverage with Waived Cost Share (atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, and simvastatin) (cont.)

Low-risk (< 5%)
Borderline risk (5% to 7.4%)
Intermediate risk (7.5% to 19.9%)
High risk (≥ 20%)

Generic Statin Medications Chart:

Generic Name	Brand Name	Form	Strength	Dosing and age limitations based on USPSTF recommendations
atorvastatin	Lipitor	oral tablet	10mg	1 daily per 30 day supply, covered age 40 and older
atorvastatin	Lipitor	oral tablet	20mg	1 daily per 30 day supply, covered age 40 and older
atorvastatin	Lipitor	oral tablet	40mg	Not applicable under preventive benefit.
atorvastatin	Lipitor	oral tablet	80mg	Not applicable under preventive benefit.
fluvastatin	Lescol	oral capsule	20mg	1 daily per 30 day supply, covered age 40 and older
fluvastatin	Lescol	oral capsule	40mg	1 daily per 30 day supply, covered age 40 and older
fluvastatin er	Lescol XL	oral capsule	80mg	1 daily per 30 day supply, covered age 40 and older
lovastatin	Mevacor	oral tablet	10mg	1 daily per 30 day supply, covered age 40 and older
lovastatin	Mevacor	oral tablet	20mg	1 daily per 30 day supply, covered age 40 and older
lovastatin	Mevacor	oral tablet	40mg	1 daily per 30 day supply, covered age 40 and older
pravastatin	Pravachol	oral tablet	10mg	1 daily per 30 day supply, covered age 40 and older
pravastatin	Pravachol	oral tablet	20mg	1 daily per 30 day supply, covered age 40 and older
pravastatin	Pravachol	oral tablet	40mg	1 daily per 30 day supply, covered age 40 and older
pravastatin	Pravachol	oral tablet	80mg	Not applicable under preventive benefit.
rosuvastatin	Crestor	oral tablet	5mg	1 daily per 30 day supply, covered age 40 and older
rosuvastatin	Crestor	oral tablet	10mg	1 daily per 30 day supply, covered age 40 and older
rosuvastatin	Crestor	oral tablet	20mg	1 daily per 30 day supply, covered age 40 and older
rosuvastatin	Crestor	oral tablet	40mg	1 daily per 30 day supply, covered age 40 and older
simvastatin	Zocor	oral tablet	5mg	1 daily per 30 day supply, covered age 40 and older
simvastatin	Zocor	oral tablet	10mg	1 daily per 30 day supply, covered age 40 and older
simvastatin	Zocor	oral tablet	20mg	1 daily per 30 day supply, covered age 40 and older
simvastatin	Zocor	oral tablet	40mg	1 daily per 30 day supply, covered age 40 and older
simvastatin	Zocor	oral tablet	80mg	Not applicable under preventive benefit. Refer to Pharmacy Coverage Guidelines for Simvastatin 80mg Products

Resources: https://uspreventiveservicestaskforce.org

Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**.
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:		Office Fax:

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: ________________________________ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. What is the diagnosis? Please specify below.

ICD-10 Code: ____________________ **Diagnosis Description:** ________________________________

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature:	Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.