Pharmacy Medical Necessity Guidelines: HMG-CoA Reductase Inhibitors

Effective: June 13, 2017

Prior Authorization Required: √
Type of Review – Care Management

Not Covered: Type of Review – Clinical Review: √

Pharmacy (RX) or Medical (MED) Benefit: RX
Department to Review: RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
☐ Tufts Health Plan Commercial Plans – large group plans
☐ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
☐ Tufts Health Direct – Health Connector
☒ Tufts Health Together – A MassHealth Plan

Tufts Health Freedom Plan products
☐ Tufts Health Freedom Plan - large group plans
☐ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM: 617.673.0988

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Crestor (rosuvastatin) is indicated for:
- Hyperlipidemia and mixed dyslipidemia
- Pediatric patients 8 to 17 years of age with heterozygous familial hypercholesterolemia
- Hypertriglyceridemia
- Primary dysbetalipoproteinemia (type III hyperlipoproteinemia)
- Homozygous familial hypercholesterolemia
- Slowing of the progression of atherosclerosis
- Primary prevention of cardiovascular disease
- Limitations: Crestor (rosuvastatin) has not been studied in Fredrickson Type I and V dyslipidemias.

Lescol (fluvastatin) and Lescol XL (fluvastatin) is indicated for:
- Hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia
- Secondary prevention of cardiovascular disease
- Limitations: Neither Lescol (fluvastatin) and Lescol XL (fluvastatin extended-release) have been studied in conditions where the major abnormality is elevation of chylomicrons, VLDL, or IDL (i.e., hyperlipoproteinemia Types I, III, IV, or V).

Livalo (pitavastatin) is indicated for:
- Primary hyperlipidemia and mixed dyslipidemia
- Limitations: Doses greater than 4 mg once daily were associated with an increased risk for severe myopathy in premarketing clinical studies. Do not exceed 4 mg once daily dosing. The effective of Livalo (pitavastatin) on cardiovascular morbidity and mortality has not been determined. Livalo (pitavastatin) has not been studied in Fredrickson Type I, III, and V dyslipidemias.

Relative LDL-lowering Efficacy of Statin Therapies*

<table>
<thead>
<tr>
<th>%↓ LDL-C</th>
<th>Atorvastatin</th>
<th>Fluvastatin</th>
<th>Pitavastatin</th>
<th>Lovastatin</th>
<th>Pravastatin</th>
<th>Rosuvastatin</th>
<th>Simvastatin</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>-----</td>
<td>40 mg</td>
<td>1 mg</td>
<td>20 mg</td>
<td>20 mg</td>
<td>-----</td>
<td>10 mg</td>
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<tr>
<td>38%</td>
<td>10 mg</td>
<td>80 mg</td>
<td>2 mg</td>
<td>40 or 80 mg</td>
<td>40 mg</td>
<td>-----</td>
<td>20 mg</td>
</tr>
<tr>
<td>41%</td>
<td>20 mg</td>
<td>-----</td>
<td>4 mg</td>
<td>80 mg</td>
<td>80 mg</td>
<td>5 mg</td>
<td>40 mg</td>
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<tr>
<td>47%</td>
<td>40 mg</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>10 mg</td>
<td>80 mg</td>
</tr>
<tr>
<td>55%</td>
<td>80 mg</td>
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<td>-----</td>
<td>-----</td>
<td>20 mg</td>
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<td>-----</td>
</tr>
<tr>
<td>63%</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>40 mg</td>
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</tbody>
</table>

*Adapted from: fda.gov/Drugs/DrugSafety/ucm256581.htm#Simvastatin_Dose_Limitations
COVERAGE GUIDELINES
The plan may authorize coverage of a non-preferred HMG-CoA Reductase Inhibitor for Members when all of the following criteria are met:

Rosuvastatin 5 mg or 10 mg
1. The Member tried and failed therapy with all of the following, or the provider indicates clinical inappropriateness of treatment with all of the following:
   a) Simvastatin ≥40 mg
   b) Pravastatin ≥40 mg
   c) Atorvastatin ≥20 mg

Rosuvastatin 20 mg or 40 mg
1. The Member tried and failed therapy, or the provider indicates clinical inappropriateness of treatment with atorvastatin 80 mg

Fluvastatin and Livalo (pitavastatin)
1. The Member tried and failed therapy with at least two alternative statins, or the provider indicates clinical inappropriateness of treatment with at least two alternative statins

LIMITATIONS
1. Coverage of all non-preferred HMG-CoA Reductase Inhibitors is limited to 30 capsules/tablets per month.
2. Requests for brand-name products, which have AB-rated generics, will be reviewing according to Non-covered Medications criteria.

CODES
None

REFERENCES


12. Lescol (fluvastatin) and Lescol XL (fluvastatin extended-release) [prescribing information]. East Hanover, NJ: Novartis; October 2012.


APPROVAL HISTORY

September 8, 2004: Reviewed by Pharmacy & Therapeutics Committee

Subsequent endorsement date(s) and changes made:

- July 19, 2012: No changes.
- July 8, 2014: Criteria for Simcor removed due to non-covered formulary status.
- March 10, 2015: Criteria modified and strength specific for Crestor; approval duration modified to one year.
- September 16, 2015: Approval duration modified to life of plan; removed renewal criteria; removed criteria related to LDL-lowering goals.
- January 1, 2016: Administrative change to rebranded template.
- June 14, 2016: Added limitation #2 “Requests for brand-name products, which have AB-rated generics, will be reviewing according to Brand Name criteria.”
- June 13, 2017: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline
and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.