

Community Care of Wake and Johnston Counties

MD Easy™ Form – Statins and Fibrates

This form MUST BE FAXED to the PHARMACY

Practice Information		Patient Information			
Practice Name		Patient Name			
Practice Address		Patient Address			
Practice City, State, Zip		Patient City, State, Zip			
Practice Phone	Practice Fax	Date of Birth		Medicaid ID	
Pharmacy Information		Originally Prescribed Fibrate		Originally Prescribed Statin	
Pharmacy Name		Drug Name/Strength		Drug Name/Strength	
Pharmacy Phone	Pharmacy Fax	Last Filled	Quantity	Last Filled	Quantity

Statins and Fibrates Prior Authorization Criteria

Criteria for Fibrates/Omacor

- Generic gemfibrozil will not require prior authorization.
- Criteria for use of generic fenofibrate:
 - Documented failure with at least a 60-day trial of generic gemfibrozil within the last 12 months.
- Criteria to use all other fibrates:
 - Documented failure with at least a 60-day trial of generic gemfibrozil and at least a 60-day trial of generic fenofibrate within the last 12 months.

Exemptions:

- Documented contraindication to, allergy to, intolerable side effect from, or drug interaction with generic gemfibrozil or generic fenofibrate.
- Patients who require Trilipix because they are on a statin medication are exempt from the criteria.
- Patients who require Lovaza because they have high triglyceride levels (> 500mg/dl) are exempt from the criteria.

Criteria for Brand Name Statins/Statin Combinations or Zetia

- Generic Lovastatin, Pravastatin, and Simvastatin will not require prior approval.
- Criteria to use all other Statin, Statin Combinations, and Zetia: Documented failure of generic simvastatin, after a period of at least two months on the maximum tolerated dose.

Exemptions:

- Documented contraindication to, allergy to, or intolerable side effect from simvastatin, lovastatin, and pravastatin.
- Patients with coronary artery disease or diabetes who are currently receiving Lipitor 80, Crestor 20, or Crestor 40.
- Patients with familial hyperlipidemia are exempt from the criteria.

**** Pharmacist may override the prior authorization at point-of-sale if the prescriber writes on the face of the prescription in his/her own handwriting: "Meets PA Criteria". ****

Please select from the below and fax to patient's pharmacy **OR** call ACS at 866-246-8505 if the patient meets criteria.

****Attention Pharmacists****

*Please discontinue originally prescribed Statin or Fibrate listed above and change patient to the approved therapy below.
If the patient does not immediately need this prescription, please keep it on file for the next refill.*

FIBRATE THERAPY	STATIN THERAPY		
<input type="checkbox"/> Gemfibrozil 600 mg	<input type="checkbox"/> Lovastatin 10 mg	<input type="checkbox"/> Pravastatin 10mg	<input type="checkbox"/> Simvastatin 5 mg
	<input type="checkbox"/> Lovastatin 20 mg	<input type="checkbox"/> Pravastatin 20 mg	<input type="checkbox"/> Simvastatin 10 mg
	<input type="checkbox"/> Lovastatin 40 mg	<input type="checkbox"/> Pravastatin 40 mg	<input type="checkbox"/> Simvastatin 20 mg
		<input type="checkbox"/> Pravastatin 80 mg	<input type="checkbox"/> Simvastatin 40 mg
			<input type="checkbox"/> Simvastatin 80 mg

Fibrate Therapy

Directions: _____
Dispense #: _____ Refill#: _____

Prescriber Signature: _____

Prescriber Name (please print): _____

Statin Therapy

Directions: _____
Dispense #: _____ Refill#: _____

Date: _____

DEA/NPI: _____

Note: By signing this document & checking the substitution above, you are consenting to this being a legal prescription & the pharmacy should fill it as such.