BlueCross BlueShield of Alabama

Statin Step Therapy Criteria Program Summary

This program applies to Commercial, SourceRx and Health Insurance Marketplace formularies.

OBJECTIVE

The intent of the Statin Step Therapy (ST) program is to encourage the use of cost-effective generic statins (HMG Co-A reductase inhibitors) prior to the use of brand statins for the management of high blood cholesterol. This 1-step program includes all brand statin or statin combination products as targets requiring use of a generic statin or statin combination prior to their use. The program allows continuation of therapy when there is documentation that the patient is receiving the requested agent. The program will evaluate use of a brand statin or statin combination product through the prior authorization process when patients are unable to take a generic statin or statin combination due to documented intolerance, FDA labeled contraindication, or hypersensitivity. Requests for brand statins or statin combinations will be reviewed when patient-specific documentation has been provided.

TARGET AGENTS (brands only)

Advicor® (niacin extended release/lovastatin)[b]
Altoprev® (lovastatin extended release)
Crestor® (rosuvastatin)[a]
Flolipid™ (simvastatin oral suspension)
Lescol® (fluvastatin)[a]
Lescol XL® (fluvastatin extended release)[a]
Lipitor® (atorvastatin)[a]
Liptruzet™ (ezetimibe/atorvastatin)
Livalo® (pitavastatin)
Mevacor® (lovastatin)[a]
Pravachol® (pravastatin)[a]
Simcor® (niacin extended release/simvastatin)
Vytorin® (ezetimibe/simvastatin)[a]
Zocor® (simvastatin)[a]

a - currently available as a generic; included as a prerequisite in step therapy program
b – generic anticipated; will be included as a prerequisite in step therapy program when available

PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

Brand Statins will be approved when ANY ONE of the following is met:

1. The patient's medication history includes use of a generic statin or statin combination in the past 90 days
   OR
2. There is documentation that the patient is currently using the requested agent
   OR
3. The prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed
   OR
4. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the available generic statin or statin combination products

Length of approval: 12 months

This pharmacy policy is not an authorization, certification, explanation of benefits or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member's plan in effect as of the date services are rendered. All pharmacy policies are based on (i) information in FDA approved package inserts (and black box warning, alerts, or other information disseminated by the FDA as applicable); (ii) research of current medical and pharmacy literature; and/or (iii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

The purpose of Blue Cross and Blue Shield of Alabama's pharmacy policies are to provide a guide to coverage. Pharmacy policies are not intended to dictate to physicians how to practice medicine. Physicians should exercise their medical judgment in providing the care they feel is most appropriate for their patients.

Neither this policy, nor the successful adjudication of a pharmacy claim, is guarantee of payment.

FDA APPROVED INDICATIONS AND DOSAGE[1-12,21]
Single Ingredient Products

Drug	Indication	Limitations of Use	Dosage
Altoprev® (lovastatin extended release) tablets	Adjunctive therapy to diet to: • Reduce the risk of MI, revascularization procedures, and angina in patients without CHD, but with multiple risk factors. • Slow the progression of coronary atherosclerosis in patients with CHD as part of a treatment strategy to lower Total-C and LDL-C. • Reduce elevated Total-C, LDL-C, Apo B, and TG levels and increase HDL-C in adult patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia.	Not studied in Fredrickson Types I, III, and V dyslipidemias.	20-60 mg once daily
Mevacor® * (lovastatin) tablets	Adjunctive therapy to diet for: • Primary prevention of coronary heart disease • To slow the progression of coronary atherosclerosis in patients with coronary heart disease as part of a treatment strategy to lower total-C and LDL-C to target levels. • Reduction of elevated total-C and LDL-C levels in patients with primary hypercholesterolemia (Types IIa and IIb2) • To reduce total-C, LDL-C and apolipoprotein B levels in adolescent boys and girls who are at least one year post-menarche, 10-17 years of age, with Heterozygous Familial Hyperlipidemia	Not studied in conditions where the major abnormality is elevation of chylomicrons, VLDL or IDL (i.e., hyperlipoproteinemia types I, III, IV, or V).	10 mg to 80 mg daily in single or two divided doses
Crestor® * (rosuvastatin) tablets	• Adult patients with primary hyperlipidemia and mixed dyslipidemia as an adjunct to diet to reduce elevated total-C, LDL-C, ApoB, nonHDL-C, and TG levels and to increase HDL-C • Pedatric patients 8 to 17 years of age with heterozygous familial hypercholesterolemia (HeFH) to reduce elevated total-C, LDL-C and ApoB after failing an adequate trial of diet therapy • Pediatric patients 7 to 17 years of age with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C, total-C, nonHDL-C and ApoB as an adjunct to diet, either alone or with other lipid-lowering treatments • Adult patients with hypertriglyceridemia as an adjunct to diet • Adult patients with primary dysbeta-lipoproteinemia (Type III	Not studied in Fredrickson Type I and V dyslipidemias.	5-40 mg once daily

Drug	Indication	Limitations of Use	Dosage
	hyperlipoproteinemia) as an adjunct to diet • Adults patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C, total-C, and ApoB • Slowing the progression of atherosclerosis as part of a treatment strategy to lower total-C and LDL-C as an adjunct to diet • Risk reduction of MI, stroke, and arterial revascularization procedures in patients without clinically evident CHD, but with multiple risk factors		
Flolipid™ (simvastatin oral suspension)	• Reduce the risk of total mortality by reducing CHD deaths and reduce the risk of non-fatal myocardial infarction, stroke, and the need for revascularization procedures in patients at high risk of coronary events. • Reduce elevated total-C, LDL-C, Apo B, TG and increase HDL-C in patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. • Reduce elevated TG in patients with hypertriglyceridemia and reduce TG and VLDL-C in patients with primary dysbetalipoproteinemia. • Reduce total-C and LDL-C in adult patients with homozygous familial hypercholesterolemia. • Reduce elevated total-C, LDL-C, and Apo B in boys and postmenarchal girls, 10 to 17 years of age with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy.	Simvastatin has not been studied in Fredrickson Types I and V dyslipidemias.	5-80 mg once daily
Lescol® * (fluvastatin) capsules	Adjunctive therapy to diet to: • Reduce elevated TC, LDL-C, Apo B, and TG, and to increase HDL-C in adult patients with primary hypercholesterolemia and mixed dyslipidemia • Reduce elevated TC, LDL-C, and Apo B levels in boys and post-menarchal girls, 10 to 16 years of age, with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy • Reduce the risk of undergoing revascularization procedures in patients with clinically evident CHD • Slow the progression of atherosclerosis in patients with CHD	Not studied in conditions where the major abnormality is elevation of chylomicrons, VLDL, or IDL (i.e., hyperlipoproteinemia Types I, III, IV, or V)	40 mg to 80 mg once daily or in two divided doses
Lescol XL® * (fluvastatin) tablets ER			80 mg once daily
Livalo® (pitavastatin)	Patients with primary hyperlipidemia or mixed dyslipidemia as an adjunctive therapy	-Doses of LIVALO greater than 4 mg	1-4 mg once daily

Drug	Indication	Limitations of Use	Dosage
tablets	to diet to reduce elevated total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), triglycerides (TG), and to increase high-density lipoprotein cholesterol (HDL-C)	once daily were associated with an increased risk for severe myopathy in premarketing clinical studies. Do not exceed 4 mg once daily dosing of LIVALO. The effect of LIVALO on cardiovascular morbidity and mortality has not been determined. LIVALO has not been studied in Fredrickson Type I, III, and V dyslipidemias.	
Lipitor® * (atorvastatin) tablets	Adjunct therapy to diet to: • Reduce the risk of MI, stroke, revascularization procedures, and angina in patients without CHD, but with multiple risk factors • Reduce the risk of MI and stroke in patients with type 2 diabetes without CHD, but with multiple risk factors • Reduce the risk of non-fatal MI, fatal and non-fatal stroke, revascularization procedures, hospitalization for CHF, and angina in patients with CHD • Reduce elevated total-C, LDL-C, apo B, and TG levels and increase HDL-C in adult patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia • Reduce elevated TG in patients with hypertriglyceridemia and primary dysbeta-lipoproteinemia • Reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia (HoFH) • Reduce elevated total-C, LDL-C, and apo B levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy	Not studied in Fredrickson Types I and V dyslipidemias.	10-80 mg once daily
Pravachol® * (pravastatin) tablets	Adjunctive therapy to diet to: • Reduce the risk of MI, revascularization, and cardiovascular mortality in	Not studied in Fredrickson Types I and V	10 mg to 80 mg once daily

Drug	Indication	Limitations of Use	Dosage
	hypercholesterolemic patients without clinically evident CHD. • Reduce the risk of total mortality by reducing coronary death, MI, revascularization, stroke/TIA, and the progression of coronary atherosclerosis in patients with clinically evident CHD. • Reduce elevated Total-C, LDL-C, ApoB, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia and mixed dyslipidemia. • Reduce elevated serum TG levels in patients with hypertriglyceridemia. • Treat patients with primary dysbeta-lipoproteinemia who are not responding to diet. • Treat children and adolescent patients ages 8 years and older with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy	dyslipidemias.	
Zocor® * (simvastatin) tablets	Adjunctive therapy to diet to: • Reduce the risk of total mortality by reducing CHD deaths and reduce the risk of non-fatal myocardial infarction, stroke, and the need for revascularization procedures in patients at high risk of coronary events. • Reduce elevated total-C, LDL-C, Apo B, TG and increase HDL-C in patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. • Reduce elevated TG in patients with hypertriglyceridemia and reduce TG and VLDL-C in patients with primary dysbeta-lipoproteinemia. • Reduce total-C and LDL-C in adult patients with homozygous familial hypercholesterolemia. • Reduce elevated total-C, LDL-C, and Apo B in boys and postmenarchal girls, 10 to 17 years of age with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy.	Not studied in Fredrickson Types I and V dyslipidemias.	5 mg to 80 mg once daily

*Generic available

Combination Products

Drug	Indication	Limitations of Use	Dosage
Advicor (niacin ER/ lovastatin) tablets	Indicated for treatment when both niacin ER and lovastatin is appropriate:		500 mg/20 mg to 1000 mg/20 mg once or twice

Drug	Indication	Limitations of Use	Dosage
	Niacin ER • Adjunct to diet for reduction of elevated TC, LDL-C, Apo B and TG levels, and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia • In patients with a history of myocardial infarction and hypercholesterolemia, niacin is indicated to reduce the risk of recurrent nonfatal myocardial infarction • Niacin is also indicated as adjunctive therapy for treatment of adult patients with very high serum triglyceride levels who present a risk of pancreatitis Lovastatin • Adjunct to diet for the reduction of elevated TC and LDL-C levels in patients with primary hypercholesterolemia • Primary prevention of cardiovascular events • Secondary prevention of cardiovascular events		daily
Liptruzet (ezetimibe/ atorvastatin) tablets	Adjunctive therapy to diet to: • Reduce elevated total-C, LDL-C, Apo B, TG, and non-HDL-C, and to increase HDL-C in patients with primary (heterozygous familial and non-familial) hyperlipidemia or mixed hyperlipidemia. • Reduce elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia (HoFH), as an adjunct to other lipid lowering treatments.	• No incremental benefit of ezetimibe/atorvastatin on cardiovascular morbidity and mortality over and above that demonstrated for atorvastatin has been established. • Ezetimibe/atorvastatin has not been studied in Fredrickson Type I, III, IV, and V dyslipidemias.	10 mg/10 mg to 10 mg/80 mg once daily
Simcor	• Reduce elevated Total–C,	• No incremental benefit of	1000 mg/20 mg

Drug	Indication	Limitations of Use	Dosage
(niacin ER/ simvastatin) tablets	LDL-C, Apo B, non-HDL-C, TG, or to increase HDL-C in patients with primary hypercholesterolemia and mixed dyslipidemia when treatment with simvastatin monotherapy or niacin extended-release monotherapy is considered inadequate. • Reduce TG in patients with hypertriglyceridemia when treatment with simvastatin monotherapy or niacin extended-release monotherapy is considered inadequate.	niacin ER/simvastatin on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin monotherapy and niacin monotherapy has been established. • Niacin extended-release, one of the components of niacin ER/simvastatin, at doses of 1,500 – 2,000 mg/day, in combination with simvastatin, did not reduce the incidence of cardiovascular events more than simvastatin in a randomized controlled trial of patients with cardiovascular disease and mean baseline LDL-C levels of 74 mg per deciliter	to 2000 mg/40 mg once daily
Vytorin (ezetimibe/ simvastatin) tablets	Adjunctive therapy to diet to: • Reduce elevated total-C, LDL-C, Apo B, TG, and non-HDL-C, and to increase HDL-C in patients with primary (heterozygous familial and non-familial) hyperlipidemia or mixed hyperlipidemia. • Reduce elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia (HoFH), as an adjunct to other lipid lowering treatments	• No incremental benefit of ezetimibe/simvastatin on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established. • Ezetimibe/simvastatin has not been studied in Fredrickson Type I, III, IV, and V dyslipidemias	10 mg/10 mg to 10 mg/80 mg once daily

*Generic available

CLINICAL RATIONALE

Statins are recommended as first-line treatment to prevent nonfatal and fatal atherosclerotic cardiovascular disease events (ASCVD) [Clinical ASCVD is defined as acute coronary syndromes, or a history of myocardial infarction (MI), or stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin].[13,15-19] Statin therapy reduces ASCVD events across the spectrum of baseline LDL-C levels ≥70 mg/dL.[13] Guidelines do not differentiate between the drugs in this class. Most people who have intolerance to a statin will still be able to take a different statin or the same statin at a lower dose.[13,14,20]

REFERENCES

1. Lipitor Prescribing Information. Pfizer. November 2015.
2. Lescol/Lescol XL Prescribing Information. Novartis. October 2012.
3. Pravachol Prescribing Information. BMS. July 2016.
4. Zocor Prescribing Information. Merck & Co. March 2015.
5. Crestor Prescribing Information. AstraZeneca. March 2017.
6. Mevacor Prescribing Information. Merck & Co. February 2014.
7. Advicor prescribing information. Abbott Laboratories. September 2013.
8. Altoprev prescribing information. Andrx Labs, Inc. April 2014.
9. Simcor prescribing information. Abbott Laboratories. August 2013.
10. Vytorin prescribing information. Merck & Co, Inc.. February 2016.
11. Livalo prescribing information. Kowa Pharmaceuticals America, Inc./Lilly USA LLC. November 2016.
12. Liptruzet Prescribing Information. Merck & Co, Inc. May 2014.
13. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline for the Treatment of Blood Cholesterol to Reduce Atherosclerotic CV risk in adults: A report of the ACC/AHA taskforce on practice guidelines. Accessed 2/5/2014 @ http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a..DC1.html
14. Backes J. Effectiveness and Tolerability of Every-other-Day Rosuvastatin Dosing in Patients with Prior Statin Intolerance. *Ann Pharmacother.* 2008 42: 341-346.
15. International Society of Nephrology. Kidney disease improving global outcomes (KDIGO) clinical practice guideline in chronic kidney disease 2013. *Kidney Int.* 2013;3(3):259-305.
16. Standards of Medical Care in Diabetes 2017. Diabetes Care 2017; 40(Suppl. 1):S75–S87 | DOI: 10.2337/dc17-S012
17. Jacobson TA, Ito MK, Maki KC, et al. National Lipid Association recommendations for patient-centered management of dyslipidemia:Part 1 – full report. *J Clin Lipidology* 2015; 9: 129-169.
18. *Jacobson TA,* Maki KC, Orringer CE, et al. National Lipid Association recommendations for patient-centered management of dyslipidemia: part 2. *J Clin Lipidology* 2015; 9: S1-S122.
19. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease: Executive Summary. Journal of the American College of Cardiology Dec 2012, 60 (24) 2564-2603; DOI: 10.1016/j.jacc.2012.07.012
20. NLA Task Force on Statin Therapy – 2014 update. Journal Clinical Lipidology 2014; 8 (3) Supplement: S1-S81
21. Simvastatin oral suspension prescribing information. Perrigo. April 2016.