



PRIOR AUTHORIZATION REQUEST FORM
Lovaza (omega-3-acid ethyl esters)

Please include patient chart notes with ALL requests

Form with fields for DATE OF REQUEST, MEMBER INFORMATION (NAME, ID #, BIRTHDATE), PROVIDER INFORMATION (NAME, NPI #, ADDRESS, PHONE #, FAX #, CONTACT NAME, PROVIDER SIGNATURE), and a checked box for PLEASE NOTE.

Drug Requested: LOVAZA

Diagnosis _____ ICD-9 code _____
Please check one [] Initial Request [] Extension Request

***Triglyceride level before initiating Lovaza therapy : _____
***If continuation of therapy also provide: Current triglyceride Level: _____

Table with 2 columns: List all previous and current medications (include history of fish oil, fibrates and nicotinic acid derivatives) and Rationale for Discontinuation.

Additional Information

Rationale for Request (co-morbidities, allergies, previous cardiac history etc.)

Submit chart notes to identify all of the following:

- All other treatments have been tried
• Expected duration of requested treatment
• Outcome for each previous drug trial
• All other pertinent information

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial 1-800-376-6373
(HMO, EPO/PPO, Option, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D 1-800-401-0915
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)