PRIOR AUTHORIZATION REQUEST FORM
Agents for Hypertriglyceridemia
(Lovaza, Omega-3-acid-ethyl ester, Vascepa)

Please include patient chart notes with ALL requests

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PRESCRIBING PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE #_____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: ☐ Lovaza ☐ Omega-3 Acid Ethyl Ester ☐ Vascepa

Diagnosis_____ **ICD-10 code** _____

Please check one: □ **Initial Request** □ **Extension Request**

***Triglyceride level *before* initiating therapy : _____

***If *continuation of therapy* please also provide: Current triglyceride Level: _____

List all previous and current medications (include history of fish oil, fibrates and nicotinic acid derivatives)	**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, Exchange, Medicaid, Child Health Plus, ASO)

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