Prior Authorization Form

CWT

Omega-3 Fatty Acids* (BSF)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Omega-3 Fatty Acids* (BSF).

Drug Name (select from list of drugs shown)

Icosapent Ethyl Lovaza (omega-3-acid ethyl esters) Omega-3-Acid Ethyl Esters

Vascepa (icosapent ethyl)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have, or did the patient have prior to the start of treatment with a triglyceride lowering drug, a triglyceride level greater than or equal to 500 milligrams/deciliter?	Y N
[If yes, then skip to question 7.]	
2. Is this request for Vascepa?	Y N
[If no, then no further questions.]	
3. Is Vascepa being prescribed to reduce the risk of myocardial infarction, stroke, coronary revascularization, or	Y N

	unstable angina requiring hospitalization in an adult patient with elevated triglyceride (TG) levels (greater than or equal to 150 milligrams/deciliter)?	
	[If no, then no further questions.]	
4.	Does the patient have established cardiovascular disease?	Y N
	[If yes, then skip to question 6.]	
5.	Does the patient have diabetes mellitus and two or more additional risk factors for cardiovascular disease?	Y N
	[If no, then no further questions.]	
6.	Is Vascepa being prescribed as an adjunct to maximally tolerated statin therapy?	Y N
	[If no, then no further questions.]	
7.	Will the patient be on an appropriate lipid-lowering diet and exercise regimen during treatment with the requested drug?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date