OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete forms will delay the authorization process**.

Omega-3 Fatty Acid Agents (Non-Preferred)

Drug Requested (select one below):	
❑ **Lovaza®** (Omega-3-acid ethyl esters 90)	❑ omega-3 acid ethyl esters

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Dosage Name/Form: _____ **Strength**: _____

Dosing Schedule/Frequency: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check applicable box below to qualify to ensure authorization will **NOT** be delayed.

- ❑ Documentation of high triglycerides of ≥ 500mg/dL

AND

- ❑ Patient is ≥ 18 years of age

OR

- ❑ Trial and failure of any other lipotropic

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/29/2017; 8/1/2017; 6/15/2018;~~ **8/27/2018**