OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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.***

Drug Requested ***(select one below)*: *Omega-3 Fatty Acid Agents*** ***(Non-Preferred)*** ***(MEDICAID)***

❑ **Lovaza®** (Omega-3-acid ethyl esters 90)	❑ omega-3 acid ethyl esters

DRUG INFORMATION*: *Complete information below. If incomplete, 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. If not checked, authorization process will 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**