

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

<input type="checkbox"/> Lovaza® (Omega-3-acid ethyl esters 90)	<input type="checkbox"/> 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 ≥ 500 mg/dL

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;