# OPTIMA HEALTH PLAN

## 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 form will delay authorization process.***

**Drug Requested** ***(select one below)*:**

| | |
|---|---|
| ❑ **Lovaza®** (Omega-3-acid ethyl esters 90) | ❑ **Vascepa®** (icosapent ethyl) |

***DRUG INFORMATION:* Complete information below. Authorization process will be delayed if incomplete.**

**Drug Name/Form/Strength:** _____

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

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

***CLINICAL CRITERIA*: *The following criteria MUST be checked to qualify or authorization process will be delayed.***

- ❑ Patient's current triglyceride level is ≥ 500mg/dl ***(submit labs documenting current level)***
- ❑ Patient has failed ***at least 90 days*** of OTC fish oil capsules at a dose of ***at least 4 grams per day.***

*****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 #:** _____

*** Approved by Pharmacy and Therapeutics Committee:** 6/15/2006
**REVISED/UPDATED:** ~~7/22/2010; 9/13/2011; 4/9/2014; 11/2/2014; 5/22/2015; 12/28/2015:1/21/2016; 3/30/2016; 4/26/2016; 12/19/2016;~~ **9/21/2017**