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;~~ **8/14/2017**;