

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Lovaza (omega-3-acid ethyl esters)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Date: _____

FDA approved indication:

Lovaza is indicated as adjunct therapy to diet to reduce very high ($\geq 500\text{mg/dl}$) triglyceride levels in adult patients.

Usage Considerations:

Excess body weight and excess alcohol intake may be important factors and should be addressed before initiating any drug therapy. Exercise can be an important ancillary measure. Diseases contributory to hyperlipidemia (such as hypothyroidism or diabetes mellitus) should be looked for and adequately treated. Certain drugs (estrogen, thiazide diuretics, and beta blockers) are sometimes associated with very significant rises in plasma TG levels. Discontinuation of the specific agent may obviate the need for specific drug therapy for hypertriglyceridemia. The use of lipid-regulating agents should be considered only when reasonable attempts have been made to obtain satisfactory results with non-drug methods. The patient should be advised that use of lipid-regulating agents does not reduce the importance of adhering to diet.

Priority Health precertification requirement:

Laboratory confirmation of triglyceride levels ($\geq 500\text{mg/dl}$)
Triglyceride level (mg/dL): _____ Date: _____

For Internal Use Only

Original Date of Req: _____ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ___

Approved: ___ Denied: ___ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N ___ Inquiry number: _____

Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MIChild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ___

Formulary (11/0030/R0) ___ Non-Formulary (11/0032/R0) ___

Dte Addt Info Req _____ by: Phone ___ Fax ___ Dte 48/OL Ltr sent: _____ Dte 2nd 48/OL Ltr Sent (Caid only) _____

Date All Info Recvd _____ Date of Decision to Deny: _____ RPh Initials: _____

Notified: _____ of Denial on: _____ by: Ph ___ Fax ___ Provider Fax #: _____