PA Request Criteria

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CAREFIRST ASO
Omega-3 Fatty Acids* (BSF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Omega-3 Fatty Acids* (BSF).

Patient Name: _____ **Date:** 11/27/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)

Icosapent Ethyl Lovaza (omega-3-acid ethyl esters) Omega-3-Acid Ethyl Esters
Vascepa (icosapent ethyl)

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Will the patient be on an appropriate lipid-lowering diet and exercise regimen during treatment with the requested drug?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed to reduce triglyceride (TG) levels in a patient with severe (greater than or equal to 500 mg/dL at baseline) hypertriglyceridemia?	**Y** ☐	**N** ☐
3.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
4.	Has the patient achieved or maintained a reduction in triglyceride (TG) levels from baseline?	**Y** ☐	**N** ☐
5.	Is Vascepa being prescribed to reduce the risk of myocardial infarction, stroke, coronary revascularization, or unstable angina requiring hospitalization in an adult patient with elevated triglyceride (TG) levels (greater than or equal to 150 mg/dL)?	**Y** ☐	**N** ☐
6.	Does the patient have established cardiovascular disease?	**Y** ☐	**N** ☐
7.	Does the patient have diabetes mellitus and two or more additional risk factors for cardiovascular disease?	**Y** ☐	**N** ☐
8.	Is Vascepa being prescribed as an adjunct to maximally tolerated statin therapy?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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