Antihyperlipidemics - icosapent ethyl (Vascepa) - Washington

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: __________________

Section B - Provider Information				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible):	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? ________________

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

UnitedHealthcare Community Plan

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Member First name:	**Member Last name:**	**Member DOB:**

Clinical and Drug Specific Information

1. Is this request for a continuation of therapy? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Cardiovascular disease. Specify (check all that apply):
     - ☐ Coronary artery disease
     - ☐ Previous myocardial infarction (MI)
     - ☐ Peripheral arterial disease (PAD)
     - ☐ Previous stroke
     - ☐ Other. Specify: ___________
   - ☐ Diabetes with at least two of the following risk factors (Check all that apply)
     - ☐ A body mass index (BMI) of 30kg/m2 or greater
     - ☐ Ankle-brachial index (ABI) below <0.9
     - ☐ Cigarette smoking
     - ☐ C-reactive protein (CRP) greater than 3mg/L
     - ☐ Creatinine clearance less than 60 mL/min
     - ☐ Retinopathy
     - ☐ Micro or macroalbuminuria
     - ☐ HDL-C less than 40 mg/dL for males or less than 50 mg/dL for females
     - ☐ Hypertension (blood pressure > 140/90mmHg or being treated with antihypertensive medication)
   - ☐ Severe hypertriglyceridemia (Greater than or equal to 500 mg/dl)
   - ☐ Other. Specify: ___________

3. Provide patient's fasting triglyceride level:
   Baseline prior to treatment with icosapent ethyl: ___________mg/dL Date checked: ___________
   Current: ___________mg/dL Date checked: ___________

4. Provide patient's low-density lipoproteins cholesterol (LDL-C):
   Baseline prior to treatment with icosapent ethyl: ___________mg/dL Date checked: ___________
   Current: ___________mg/dL Date checked: ___________

5. Does patient have a history of failure as stated below, contraindication, or intolerance to any of the following (check all that apply):
   - ☐ A statin at the highest tolerated dose for a minimum of 3 months
   - ☐ A fibrate medication (fenofibrate or gemfibrozil) for a minimum of 3 months
   - ☐ Omega-3-acid ethyl esters (must be a legend product) for a minimum of 3 months
   - ☐ Other contraindication or intolerance. Specify drug and describe: ______________________

6. Indicate patient's current high-intensity statin regimen:
   - ☐ Atorvastatin. Specify daily dose: ___________
   - ☐ Rosuvastatin. Specify daily dose: ___________
   - ☐ High intensity statin cannot be tolerated.
     Specify the current statin regimen (name and daily dose):___________
   - ☐ Statin is contraindicated in patient. Clinical documentation of contraindication required.

7. Will the patient continue to take the maximum tolerated dose of statin, unless contraindicated or intolerant to statin therapy? ☐ Yes ☐ No

8. Will icosapent ethyl be used as an adjunct to diet modifications (e.g. low-fat diet, alcohol avoidance, and reduction in refined carbohydrates)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date