Prior Authorization Request Form for
omega-3-acid ethyl esters **(Lovaza)** and icosapent ethyl **(Vascepa)**

JOHNS HOPKINS MEDICINE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of hypertriglyceridemia [1] ?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Does the patient have a current triglyceride (TG) level less than 500 mg/dl ?	☐ Yes Proceed to question 3	☐ No Sign and date below
3. Is the patient currently taking a statin?	☐ Yes Proceed to Question 4	☐ No **Skip** to Question **5**
4. Has the patient had an inadequate TG-lowering response to a therapeutic trial of niacin (1-2 g/day) OR fibrates, or is unable to tolerate niacin or fibrates, or is not a candidate for niacin or fibrate therapy?	☐ Yes Sign and date below	☐ No **STOP** Coverage not approved
5. Has the patient had an inadequate TG-lowering response to a therapeutic trial of niacin (1-2 g/day) AND fibrates, is unable to tolerate BOTH niacin AND fibrates, or is not a candidate for BOTH niacin AND fibrate therapy?	☐ Yes Sign and date below	☐ No **STOP** Coverage not approved

[1] Coverage is not approved for use in non-FDA approved conditions, including the following: Attention Deficit Hyperactivity Disorder, Alzheimer's disease, bipolar disease, Crohn's disease, cystic fibrosis, dementia, depression, inflammatory bowel disease, intermittent claudication, metabolic syndrome, osteoporosis, post-traumatic stress disorder, renal disease (immunoglobulin A nephropathy), rheumatoid arthritis, schizophrenia, Type 2 diabetes mellitus, and ulcerative colitis.

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[4 January 2016]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: