

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, OMEGA-3 ACIDS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Instructions, F-00162A. Providers may refer to the Forms page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms> for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form signed by the prescriber before submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

SECTION II – PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Directions for Use

8. Name – Prescriber

9. National Provider Identifier – Prescriber

10. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION (Required for all PA requests.)

12. Diagnosis Code and Description

13. Is the member 18 years of age or older?

Yes

No

Note: A copy of the member's current lipid panel report within the past 60 days must be submitted with all PA requests.

14. List the member's most recent lipid panel and date taken.

Date of Lipid Panel _____

Total Cholesterol _____

High-Density Lipoprotein (HDL) Cholesterol _____

Low-Density Lipoprotein (LDL) Cholesterol _____

Triglyceride Level _____



SECTION IIIA – CLINICAL INFORMATION FOR SEVERE HYPERTRIGLYCERIDEMIA (500 MG/DL OR GREATER) ONLY

15. Has the member's triglyceride level been measured at 500 mg/dL or greater? Yes No

If yes, list the member's highest triglyceride level and the test date.

Triglyceride Level _____ Test Date _____

16. Has the member taken the maximum dose of a preferred omega-3 acid **for at least four consecutive months** and failed to achieve at least a 30 percent decrease in triglyceride level from baseline? Yes No

If yes, provide the name of the preferred omega-3 acid taken. _____

List the dates the preferred omega-3 acid was taken. _____

List the daily dose of the preferred omega-3 acid. _____

List the member's baseline triglyceride level prior to starting the preferred omega-3 acid and the test date.

Triglyceride Level _____ Test Date _____

List the member's triglyceride levels during treatment with the preferred omega-3 acid and test date.

Triglyceride Level _____ Test Date _____

Triglyceride Level _____ Test Date _____

SECTION IIIB – CLINICAL INFORMATION FOR ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) RISK REDUCTION ONLY

Note: A copy of the member's medical records must be submitted with the initial PA request.

17. Is the member currently taking a maximized statin regimen? Yes No

If yes, list the member's current maximized statin regimen, including the drug name, drug strength, dosing regimen, and start date.

Drug Name _____ Drug Strength _____

Dosing Regimen _____ Start Date _____

Has the member taken the above maximized statin regimen **for at least three consecutive months** with failure to reach a triglyceride level of less than 150 mg/dl? Yes No

Will the member continue to take the above maximized statin regimen along with the requested non-preferred lipotropic, omega-3 acid? Yes No

18. Does the member have clinical ASCVD? Yes No

Clinical documentation must provide evidence of at least one of the following (check all that apply):

The member has coronary artery disease, which is supported by a history of myocardial infarction (heart attack), coronary revascularization, or angina pectoris.

The member has a history of non-hemorrhagic stroke.

The member has symptomatic peripheral arterial disease as evidenced by one of the following (check all that apply):

Intermittent claudication with an ankle-brachial index of less than 0.85

Peripheral arterial revascularization procedure

Amputation due to atherosclerotic disease

19. Does the member have diabetes mellitus? Yes No

If yes, indicate whether the member has any of the following ASCVD risk factors: (Check all that apply.)

- Congestive heart failure
- Current Smoker
- Estimated glomerular filtration rate less than 60 mL/min/1.73 m²
- Hypertension
- Obesity

SECTION IV – AUTHORIZED SIGNATURE

20. **SIGNATURE** – Prescriber

21. Date Signed – Prescriber

SECTION V – ADDITIONAL INFORMATION

22. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.
