DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00162 (07/13)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, OMEGA-3 ACIDS

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions, F-00162A, for more information. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

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

2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber

6. Address — Prescriber (Street, City, State, ZIP+4 Code)

7. Telephone Number — Prescriber

8. Name — Billing Provider	9. NPI — Billing Provider

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name

11. Drug Strength	12. Date Prescription Written
13. Directions for Use	14. Refills

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

15. Diagnosis Code and Description

16. Does the member have an allergy or sensitivity to fish? ❑ Yes ❑ No

17. 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 _____

18. List the member's most recent lipid panel and date taken. (Date must be within the past three months.)

Date of Lipid Panel _____

Total Cholesterol _____

High-Density Lipoprotein (HDL) Cholesterol _____

Low-Density Lipoprotein (LDL) Cholesterol _____

Triglyceride _____

Continued

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

19. List the member's current lipid- and triglyceride-lowering therapy.

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR MEMBERS CURRENTLY TAKING AN OMEGA-3 ACID

20. Has the member's triglyceride level decreased by 20 percent or more from baseline? ❑ Yes ❑ No

If yes, list the member's baseline triglyceride level prior to starting an Omega-3 Acid and the date the test was taken.

Triglyceride Level _____ Test Date _____

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED OMEGA-3 ACID REQUESTS ONLY

21. In the last year, has the member taken the maximum dose of Lovaza® 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, list the dates Lovaza® was taken for the Lovaza® trial. _____

List the daily dose of Lovaza®. _____

List the member's baseline triglyceride level prior to starting Lovaza® and the date taken.

Triglyceride Level _____ Test Date _____

List the member's triglyceride levels during treatment with Lovaza® and test date.

Triglyceride Level _____ Test Date _____

Triglyceride Level _____ Test Date _____

SECTION IV — AUTHORIZED SIGNATURE

22. **SIGNATURE** — Prescriber	23. Date Signed — Prescriber

SECTION V — ADDITIONAL INFORMATION

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

Reset Form