DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00162 (07/2017)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 ID 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 _____

Continued

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

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 _____

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 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 date taken.

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 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