DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00162 (07/2023)

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

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. Prescribers 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 and dated by the prescriber before submitting a PA request on the Portal, by fax, or by mail. Prescribers and pharmacy 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

Note: A copy of the member's current lipid panel report within the past 30 days must be submitted with all PA requests.

13. List the member's current lipid panel and date taken.

Date of Lipid Panel _____

Total Cholesterol _____

High-Density Lipoprotein (HDL) Cholesterol _____

Low-Density Lipoprotein (LDL) Cholesterol _____

Triglyceride Level _____

Note: For severe hypertriglyceridemia use (500 mg/dL or greater), **complete Section III A**.
For atherosclerotic cardiovascular disease (ASCVD) risk reduction use, **complete Section III B**.

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR SEVERE HYPERTRIGLYCERIDEMIA USE (500 MG/DL OR GREATER)

14. 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 _____

15. Has the member taken the maximum dose of a preferred omega-3 acid **for at least three consecutive months** and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ☐ Yes ☐ No

If yes, list the preferred lipotropics, omega-3 acid used. _____

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

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR ASCVD RISK REDUCTION USE

16. 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

17. Does the member have clinical ASCVD? ☐ Yes ☐ No

If yes, 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

18. Does the member have diabetes mellitus? ☐ Yes ☐ No

If yes, indicate which of the following ASCVD risk factors the member has (check all that apply):

- ☐ Congestive heart failure
- ☐ Current smoker
- ☐ Estimated glomerular filtration rate less than 60 mL/min/1.73 m^2
- ☐ Hypertension
- ☐ Obesity

SECTION IV – AUTHORIZED SIGNATURE

19. **SIGNATURE** – Prescriber	20. Date Signed

SECTION V – ADDITIONAL INFORMATION

21. 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