

**FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LOVAZA®**

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Lovaza® Completion Instructions, F-00162I, for more information.

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 <i>Lovaza</i>	
11. Drug Strength	12. Date Prescription Written
13. Directions for Use	14. Refills

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description

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

Total Cholesterol	_____
High-density lipoprotein (HDL) cholesterol	_____
Low-density lipoprotein (LDL) cholesterol	_____
Triglyceride	_____

17. Indicate the date of the lipid panel.

SECTION IV — INITIAL COVERAGE REQUIREMENTS

18. Does the member have an allergy or sensitivity to fish?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Does the member have a medical condition (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is the member compliant with the prescribed treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Is the member taking a medication (e.g., beta blocker, thiazide, estrogen) that may contribute to hypertriglyceremia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, has the medication been evaluated and modified if appropriate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Continued



SECTION IV — INITIAL COVERAGE REQUIREMENTS (Continued)

21. Has the prescriber evaluated and discussed lifestyle modifications (e.g., diet, exercise, weight loss, alcohol consumption) with the member that may improve his or her triglyceride levels? Yes No

22. List the member's current lipid- and triglyceride-lowering therapy, including all medication names, daily doses, and start dates.

23. Has the member's triglyceride level been 500 mg/dL or greater in the past five years? Yes No

If yes, provide the triglyceride level and the date of the test.

SECTION V — AUTHORIZED SIGNATURE

24. SIGNATURE — Prescriber

25. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

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

SECTION VII — FOR INTERNAL USE ONLY

- Initial request — Four months for members with current triglyceride levels of 500 mg/dL and above.
 - Initial request — Four months for members with current triglyceride levels between 200 and 499 mg/dL who are taking a fibrate or niacin *and* have a triglyceride level over 500 mg/dL in the past five years.
 - Renewal request — 12 months for members whose triglyceride level decreased or is maintained at a minimum of 20 percent below baseline.
-