**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code §§ DHS 107.10(2)

F-00162 (07/2024)

**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.

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| **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 | | |

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| **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 lipotropics, 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 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 or equal to 0.9  Peripheral arterial revascularization procedure or 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 m2  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. | |