

**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**

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

2. Member ID Number

3. Date of Birth – Member

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**SECTION II – PRESCRIPTION INFORMATION**

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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

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**SECTION III – CLINICAL INFORMATION (Required for All PA Requests)**

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12. Diagnosis Code and Description

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

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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.**

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

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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 \_\_\_\_\_

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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.

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

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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

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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

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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<sup>2</sup>
- Hypertension
- Obesity

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**SECTION IV – AUTHORIZED SIGNATURE**

19. **SIGNATURE** – Prescriber

20. Date Signed

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**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.

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