

# VASCEPA

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

Date of Service (if differs from Today’s Date): \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis- ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. Is the patient currently treated with the requested agent?.....  Yes  No
2. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
If yes, please specify FDA labeled contraindications: \_\_\_\_\_
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent?.....  Yes  No  
If no, please provide support for using the requested agent for the patient’s age for the requested indication: \_\_\_\_\_
4. Does the patient have a diagnosis of severe hypertriglyceridemia (fasting triglyceride level of greater than or equal to 500 mg/dL)? .....  Yes  No
5. Is the patient using the requested agent to reduce the risk of myocardial infarction, stroke, coronary revascularization, or unstable angina requiring hospitalization? .....  Yes  No
6. Is the patient on maximally tolerated statin therapy? .....  Yes  No  
If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) statin-related rhabdomyolysis, 2) statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) statin-related elevated hepatic transaminase? .....  Yes  No  
If no, does the patient have a hypersensitivity to at least ONE statin? .....  Yes  No  
If yes, please explain hypersensitivity: \_\_\_\_\_
7. Does the patient have a fasting triglyceride level greater than or equal to 135 mg/dL? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For all requests:**

8. Does the patient have established cardiovascular disease (CVD) AND has ONE of the following: 1) acute coronary syndrome, 2) history of myocardial infarction, 3) stable or unstable angina, 4) coronary or other arterial revascularization, 5) stroke, 6) transient ischemic attack, or 7) peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin? .....  Yes  No  
 If no, does the patient have diabetes mellitus AND TWO or more additional risk factors for cardiovascular disease? .....  Yes  No
9. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For renewal requests:**

10. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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