Vascepa (icosapent ethyl)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Hypertriglyceridemia ☐ Severe hypertriglyceridemia ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Initial Request:

Is the prescriber a cardiologist or lipid specialist? ☐ Yes ☐ No

Does the patient have a recent Triglyceride level ≥ 150mg/dL and <500mg/dL? ☐ Yes ☐ No ***Please submit documentation***

Does the patient have established cardiovascular disease? ☐ Yes ☐ No

Does the patient have diabetes with at least 2 cardiovascular risks? ☐ Yes ☐ No ***Please submit documentation***

☐ age ≥ 65 years
☐ history of MI
☐ stroke
☐ peripheral artery disease (PAD)
☐ stent placement
☐ CHF
☐ BMI >___?__
☐ smoker
☐ high LDL-C ≥ 100 mg/dL when not on a statin
☐ hypertension

Does the patient have a recent LDL level between 41 mg/dL and 100 mg/dL? ☐ Yes ☐ No
Please submit documentation.

Has the patient been on statin therapy for at least the previous 4 weeks? ☐ Yes ☐ No

Will the patient remain on statin therapy while on Vascepa? ☐ Yes ☐ No

For patients who have diabetes: Does the patient have a hemoglobin A1C level greater than 10.0%, as documented by a submitted lab report dated within the past six months? ☐ Yes ☐ No

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Renewal Request:

Is patient continuing to take a statin? □ **Yes** □ **No**

For patient with severe hypertriglyceridemia, please answer the following:

Is patient's triglyceride level ≥ 500 mg/dL AND ≤ 2000 mg/dL? □ **Yes** □ **No** ***Please submit documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811