

**PRIOR AUTHORIZATION REQUEST FORM**

**VASCEPA®**

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

**Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.**

**Product being requested:**  Vascepa® (icosapent ethyl)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section.**

Questions	Yes	No	Comments/Notes
<b>HYPERTRIGLYCERIDEMIA</b>			
1. Does the member have a diagnosis of severe hypertriglyceridemia with triglyceride (TG) level >500mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a 3-month trial and failure or contraindication to a fibrate (fenofibrate, gemfibrozil) and a preferred generic omega-3-acid ethyl ester?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CARDIOVASCULAR RISK REDUCTION WITH MILD HYPERTRIGLYCERIDEMIA</b>			
1. Is the member >45 years of age with an established cardiovascular disease (e.g. coronary artery disease, cerebrovascular, carotid artery, or peripheral artery disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member >50 years of age with diabetes (A1c <10.0%) in combination with at least one of the following additional risk factor for cardiovascular disease: <ul style="list-style-type: none"> <li>• Retinopathy</li> <li>• Microalbuminuria or macroalbuminuria</li> <li>• Renal dysfunction (CrCl &lt;60mL/min)</li> <li>• Hypertension (BP ≥140/90mmHg)</li> <li>• Men ≥55 years of age or women ≥65 years of age</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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<ul style="list-style-type: none"> <li>• HDL <math>\leq</math>40mg/dL for men or <math>\leq</math>50mg/dL for women</li> <li>• ABI <math>&lt;</math>0.9</li> </ul>			
3. Does the member have a history of NYHA class IV heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a history of severe liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the member currently taking a moderate to high intensity statin?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will the moderate to high intensity statin be continued in combination with Vascepa®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation show triglyceride level of 135 to 499mg/dL and LDL level of 40 to 100mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.</b>			
Additional information:			
Physician Signature:			

**\*\*Failure to submit clinical documentation to support this request will result in delay and/or denial of the request\*\***

Policy: PHARM-090  
 Origination Date: 12/12/2019  
 Reviewed/Revised Date: 04/26/2021  
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