UnitedHealthcare Community Plan

LOVAZA

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐ Yes ☐ No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-9 CODE:**

FOR INITIAL REQUESTS:

What is the patient's triglyceride (TG) level? _____ mg/dL

FOR REAUTHORIZATION REQUESTS:

Has the patient's triglyceride (TG) level decreased due to Lovaza therapy? YES or **NO** *(circle response)*

List initial triglyceride level: _____ mg/dL

List current triglyceride level: _____ mg/dL

Explanation of why the preferred medication(s) would not meet your patient's needs:

Other Medications Tried

Medication, Strength, and Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ Date: _____