

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 <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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-10 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 (<i>circle response</i>)			
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:** _____

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