ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Omega - Colorado
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Omega - Colorado
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS – SEVERE HYPERTRIGLYCERIDEMIA	
□ Yes □ No	**Does the patient have a diagnosis of severe hypertriglyceridemia (pre-treatment triglyceride level greater than or equal to 500 mg/dL)?** *If yes, list pre-treatment triglyceride level: _____ mg/dL*
□ Yes □ No	**Is the patient on an appropriate lipid-lowering diet and exercise regimen?**
□ Yes □ No	**Does the patient have a history of failure to at least 90 days of a fibric acid derivative?** *(If yes, please complete Section D above)*
□ Yes □ No	**Does the patient have a contraindication or intolerance to a fibric acid derivative?** *If yes, list contraindication or intolerance:*
□ Yes □ No	**Does the patient have a history of failure, intolerance, or contraindication to omega-3-acid ethyl esters (generic Lovaza)?** *(If yes, please complete Section D above)*
CONTINUATION OF THERAPY- SEVERE HYPERTRIGLYCERIDEMIA	
□ Yes □ No	**Does the patient have a documented positive clinical response to therapy?**
□ Yes □ No	**Is the patient on an appropriate low-fat diet and exercise regimen?**
VASCEPA – MODERATE HYPERTRIGLYCERIDEMIA	
□ Yes □ No	**Does the patient have a diagnosis of moderate hypertriglyceridemia (pre-treatment triglyceride level 150mg/dL to 499 mg/dL)?**
□ Yes □ No	**Does the patient currently have or is considered high or very high risk for cardiovascular disease (CVD) as evidenced by one of the following?** *(If yes, check which applies)* □ Age greater than or equal to 45 □ Diagnosis of Type 2 diabetes □ Established CVD confirmed by one of the following: • Acute coronary syndrome • Coronary or other arterial revascularization • History of myocardial infarction • Peripheral arterial disease • Stable or unstable angina • Stroke • Transient ischemic attack
□ Yes □ No	**Does the patient have two of the following risk factors for developing cardiovascular disease?** *(If yes, check which applies)* □ Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication □ Cigarette smoker or stopped smoking within the past 3 months □ Creatinine clearance greater than 30 and less than 60 mL/min □ HDL-C (high-density lipoprotein cholesterol) ≤ 40 mg/dL for men or ≤ 50 mg/dL for women □ High-sensitivity C-reactive protein greater than 3.0 mg/L □ Hypertension (pretreatment blood pressure greater than or equal to 140 mm/Hg systolic or greater than or equal to 90 mm/Hg diastolic) □ Men ≥ 55 years and women ≥ 65 years of age □ Micro- or macro-albuminuria □ Retinopathy

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Omega - Colorado
Prior Authorization Request Form

□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting any of the following be submitted along with this fax?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient has been receiving at least 12 consecutive weeks of high- intensity statin therapy (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive a high-intensity statin at maximally tolerated dose □ Patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e. more than 2 weeks) symptoms: • Myalgia (muscle symptoms without creatine kinase (CK) elevations) • Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]) □ Patient has been receiving at least 12 consecutive weeks of moderate-intensity [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 20 mg, pravastatin greater than or equal to 40 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 2 mg] statin therapy and will continue to receive a moderate-intensity statin at maximally tolerated dose □ Patient has been receiving at least 12 consecutive weeks of low-intensity [i.e. simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1 mg] statin therapy and will continue to receive a low-intensity statin at maximally tolerated dose
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting any of the following be submitted along with this fax?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy □ Patient has a history of contraindication or intolerance to ezetimibe □ Patient has an LDL-C (low density lipoprotein cholesterol) less than 100 mg/dL while on maximally tolerated statin therapy
□ **Yes** □ **No**	**Will Vascepa be used as an adjunct to a low-fat diet and exercise?**
□ **Yes** □ **No**	**Is Vascepa prescribed by or in consultation with any of the following?** *(if yes, check which applies)* □ Cardiologist □ Endocrinologist □ Lipid specialist
□ **Yes** □ **No**	**Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided?**
CONTINUATION OF THERAPY (VASCEPA – MODERATE HYPERTRIGLYCERIDEMIA)	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response to therapy?**
□ **Yes** □ **No**	**Is the patient on an appropriate low-fat diet and exercise regimen?**
□ **Yes** □ **No**	**Is the patient receiving maximally tolerated statin therapy?**
□ **Yes** □ **No**	**Is Vascepa prescribed by or in consultation with any of the following?** *(if yes, check which applies)* □ Cardiologist □ Endocrinologist □ Lipid specialist

Provider Signature: _____ **Date:** _____