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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Vascepa® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Severe hypertriglyceridemia					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Does the patient have a history of cardiovascular disease (CVD)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient been on appropriate statin therapy for at least 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will medical records (e.g., chart notes, lab results) documenting elevated triglycerides (fasting value > 200mg/dL) at qualifying or baseline visit be submitted along with this fax?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
* Please submit documentation (e.g., chart notes, lab results) along with this fax					
Is the patient on a stable lipid-lowering diet and exercise regimen, as defined by the same pattern for the previous 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
If this is a reauthorization request, answer the following:					
Does the patient have a history of cardiovascular disease (CVD)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient continue to be on appropriate statin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will medical records (e.g., chart notes, lab results) documenting positive response to therapy (i.e., decrease in triglyceride levels) be submitted along with this fax?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
* Please submit documentation (e.g., chart notes, lab results) along with this fax					
Does the patient continue to be on stable lipid-lowering diet and exercise regimen, as defined by the same pattern for the previous 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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