HEALTH PLANS
UNIVERSITY OF UTAH

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: 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
HYPERTRIGLYCERIDEMIA			
1. Does the member have a diagnosis of severe hypertriglyceridemia with triglyceride (TG) level >500mg/dL?	☐	☐	**Please provide documentation**
2. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	☐	☐	
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?	☐	☐	**Please provide documentation**
CARDIOVASCULAR RISK REDUCTION WITH MILD HYPERTRIGLYCERIDEMIA			
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)?	☐	☐	**Please provide documentation**
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: • Retinopathy • Microalbuminuria or macroalbuminuria • Renal dysfunction (CrCl <60mL/min) • Hypertension (BP ≥140/90mmHg) • Men ≥55 years of age or women ≥65 years of age • HDL ≤40mg/dL for men or ≤50mg/dL for women	☐	☐	**Please provide documentation**

• ABI <0.9			
3. Does the member have a history of NYHA class IV heart failure?	☐	☐	
4. Does the member have a history of severe liver disease?	☐	☐	
5. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	☐	☐	
6. Is the member currently taking a moderate to high intensity statin?	☐	☐	**Please provide documentation**
7. Will the moderate to high intensity statin be continued in combination with Vascepa®?	☐	☐	**Please provide documentation**
8. Does documentation show triglyceride level of 135 to 499mg/dL and LDL level of 40 to 100mg/dL?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
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.			
Additional information:			
Physician Signature:			

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Policy: PHARM-090
Origination Date: 12/12/2019
Reviewed/Revised Date: 05/18/2022
Next Review Date: 05/18/2023
Current Effective Date: 06/01/2022