OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Severe hypertriglyceridemia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a history of cardiovascular disease (CVD)? ❑ **Yes** ❑ **No**

Has the patient been on appropriate statin therapy for at least 90 days? ❑ **Yes** ❑ **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?* ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient have a history of cardiovascular disease (CVD)? ❑ **Yes** ❑ **No**

Does the patient continue to be on appropriate statin therapy? ❑ **Yes** ❑ **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?* ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **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.

Office use only: Vascepa_CulinaryHealthFund_2019Apr-MD