

**CAREFIRST - MD EXCHANGE 5T
Omega-3 Fatty Acids (HMF)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Omega-3 Fatty Acids (HMF).

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Drug Name (select from list of drugs shown)

Omega-3-Acid CAP 1 GM

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Does the patient have, or did the patient have prior to the start of treatment with a triglyceride lowering drug, a triglyceride level greater than or equal to 500 milligrams/deciliter? Y N
2. Is this request for Vascepa? Y N
3. Is Vascepa being prescribed to reduce the risk of myocardial infarction, stroke, coronary revascularization, or unstable angina requiring hospitalization in an adult patient with elevated triglyceride (TG) levels (greater than 150 milligrams/deciliter)? Y N
4. Does the patient have established cardiovascular disease? Y N
5. Does the patient have diabetes mellitus and two or more additional risk factors for cardiovascular disease? Y N
6. Is Vascepa being prescribed as an adjunct to maximally tolerated statin therapy? Y N
7. Will the patient be on an appropriate lipid-lowering diet and exercise regimen during treatment? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark