Wellpoint

Omega-3 Fatty Acids
Prior Authorization of Benefits Form

Contains confidential patient information
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: ____	Prescribing physician: ____
Patient ID #: ____	Physician address: ____
Patient DOB: ____	Physician phone #: ____
Date of Rx: ____	Physician fax #: ____
Patient phone #: ____	Physician specialty: ____
Patient email address: ____	Physician DEA: ____
	Physician NPI #: ____
	Physician email address: ____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
			Specify:

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes	□ No	Patient is greater than or equal to 18 years of age.
□ Yes	□ No	Patient has a diagnosis of hypertriglyceridemia in the last 365 days.
□ Yes	□ No	Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
□ Yes	□ No	Patient has a documented allergy or contraindication to preferred agents in this class.
□ Yes	□ No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
□ Yes	□ No	Does the client have severe hypertriglyceridemia (TG ≥ 500mg/dL) in the last 365 days?
□ Yes	□ No	Has the patient failed a 30-day treatment trial with a fibrate in the last 180 days?
□ Yes	□ No	Does the client have elevated triglyceride levels (TG ≥ 150mg/dL) AND diabetes mellitus or established cardiovascular disease in the last 365 days?
□ Yes	□ No	Is the client currently on maximally tolerated statin therapy, or does the client have an intolerance or contraindication to statin therapy?

Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.

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For the *Medicaid Preferred Drug List,* please refer to the Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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