coordinated care

Antihyperlipidemics - icosapent ethyl (Vascepa)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Cardiovascular disease. Specify (check all that apply):
     - ☐ Coronary artery disease
     - ☐ Peripheral arterial disease (PAD)
     - ☐ Other. Specify: _____
     - ☐ Previous myocardial infarction (MI)
     - ☐ Previous stroke
   - ☐ Diabetes with at least two of the following risk factors (Check all that apply)
     - ☐ A body mass index (BMI) of 30kg/m2 or greater
     - ☐ Cigarette smoking
     - ☐ Creatinine clearance less than 60 mL/min
     - ☐ Micro or macroalbuminuria
     - ☐ HDL-C less than 40 mg/dL for males or less than 50 mg/dL for females
     - ☐ Hypertension (blood pressure > 140/90mmHg or being treated with antihypertensive medication)
     - ☐ Ankle-brachial index (ABI) below <0.9
     - ☐ C-reactive protein (CRP) greater than 3mg/L
     - ☐ Retinopathy
   - ☐ Severe hypertriglyceridemia (Greater than or equal to 500 mg/dl)
   - ☐ Other. Specify: _____

3. Provide patient's fasting triglyceride level:
   Baseline prior to treatment with icosapent ethyl: _____mg/dL Date checked: _____
   Current: _____mg/dL Date checked: _____

4. Provide patient's low-density lipoproteins cholesterol (LDL-C):
   Baseline prior to treatment with icosapent ethyl: _____mg/dL Date checked: _____
   Current: _____mg/dL Date checked: _____

5. Does patient have a history of failure as stated below, contraindication, or intolerance to any of the following (check all that apply):
   - ☐ A statin at the highest tolerated dose for a minimum of 3 months
   - ☐ A fibrate medication (fenofibrate or gemfibrozil) for a minimum of 3 months
   - ☐ Omega-3-acid ethyl esters (must be a legend product) for a minimum of 3 months
   - ☐ Other contraindication or intolerance. Specify drug and describe: _____

6. Indicate patient's current high-intensity statin regimen:
   - ☐ Atorvastatin. Specify daily dose: _____
   - ☐ Rosuvastatin. Specify daily dose: _____
   - ☐ High intensity statin cannot be tolerated.
     Specify the current statin regimen (name and daily dose):_____
   - ☐ Statin is contraindicated in patient. Clinical documentation of contraindication required.

7. Will the patient continue to take the maximum tolerated dose of statin, unless contraindicated or intolerant to statin therapy? ☐ Yes ☐ No

8. Will icosapent ethyl be used as an adjunct to diet modifications (e.g. low-fat diet, alcohol avoidance, and reduction in refined carbohydrates)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)