

# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested:** icosapent ethyl (Vascepa®)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member AvMed #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**DIAGNOSIS - Hypertriglyceridemia (severe).** ALL of the following criteria must be met:

- Member's current triglyceride level is  $\geq 500$  mg/dL (**submit labs documenting current level**)

**AND**

- Member is on an appropriate lipid-lowering diet and exercise regimen

**AND**

- Member has a history of failure or intolerance (at least 90 days) to **TWO** of the following medications (**Check all that apply; submit documentation of intolerance and/or contraindication; pharmacy claims will be reviewed**)
- Fibrate (e.g., fenofibrate, gemfibrozil)
  - Statin (e.g., atorvastatin, rosuvastatin)
  - Omega-3-acid ethyl esters (generic Lovaza)

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**DIAGNOSIS - Cardiovascular Event Risk Reduction.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member's current triglycerides are between 150 and 499 mg/dL (**submit labs documenting current level**)

**AND**

- Use is adjunctive to maximally-tolerated statin therapy unless contraindicated per FDA label or intolerance (**submit documentation of intolerance or contraindication; pharmacy claims will be reviewed**)

**AND** (Select **ONE** of the following):

- Member is  $\geq 45$  years old with established cardiovascular disease defined by **ONE** the following: (**submit chart notes and/or lab documentation**)
- Documented coronary artery disease (multi-vessel CAD, prior MI, or hospitalization for high risk non-ST segment elevation acute coronary syndrome (NSTEMI-ACS))
  - Documented carotid artery disease (prior ischemic stroke, arterial stenosis, history of carotid revascularization)
  - Documented peripheral artery disease (Ankle-brachial index (ABI)  $< 0.9$  with symptoms of intermittent claudication, history of aorto-iliac or peripheral arterial intervention)

**OR**

- Member is  $> 50$  years old with diabetes mellitus (Type I or Type II) with **TWO** of the following additional risk factors for CVD. Check all that apply; select at least **TWO** additional risk factors below: (**submit chart notes and/or lab documentation**)
- Men  $> 55$  or women  $> 65$  years of age
  - Cigarette smoker (or recently quit)
  - Hypertension or on antihypertensive medication
  - Low HDL-C (e.g., HDL-C  $< 40$  mg/dL or  $< 50$  mg/d L for women)
  - Renal dysfunction: (CrCL  $> 30$  and  $< 60$  mL/min)
  - Retinopathy
  - Presence of albuminuria
  - Elevated biomarkers associated with ASCVD (e.g., hs-CRP  $> 3.00$ mg/L, ABI  $< 0.9$  without symptoms)

*Not all drugs may be covered under every Plan.*

*If a drug is non-formulary on a Plan, documentation of medical necessity will be required.*

*\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\**

*\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\**