Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Hyperlipidemia Medications (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Hyperlipidemia Medications (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Epanova (omega-3-carboxylic acids) Lovaza (omega-3-acid ethyl esters) Vascepa (icosapent ethyl)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 4.]

2. Has the patient had a lipid panel within the past 90 days showing an improvement in fasting lipids? Y N

   [If no, then no further questions.]

3. Is the patient compliant or adherent to adjunctive lipid lowering therapies? Y N

   [No further questions.]

4. Is the patient on an appropriate lipid-lowering diet and exercise regimen? Y N

   [If no, then no further questions]

5. Is the requested drug being prescribed for the treatment of severe hypertriglyceridemia (triglyceride level greater than or equal to 500mg per dL)? Y N

   [If no, then no further questions]

6. Is the patient 18 years of age or older? Y N

   [If no, then no further questions.]

7. Has the patient experienced an inadequate treatment response to OTC (over the counter) fish oil and a fibrate, fenofibric acid, or gemfibrozil? Y N

   Please list formulary medications trialed:

   _____

   [If yes, then no further questions]

8. Has the patient experienced contraindication to all formulary agents? Y N

   Please specify contraindications if applicable:

   _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**