Prescriber Criteria Form

Lovaza 2024 PA Fax 2480-A v1 010124.docx
Lovaza (omega-3-acid ethyl esters)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lovaza (omega-3-acid ethyl esters).

Drug Name:
Lovaza (omega-3-acid ethyl esters)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of severe hypertriglyceridemia? [If no, then no further questions.]	Yes	No
2	Prior to the start of treatment with a triglyceride lowering drug, has/had the patient's pretreatment triglyceride level been greater than or equal to 500 mg/dL?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____