PRESCRIPTION FORM

PATIENT INFORMATION			PRESCRIBER INFORMATION
PATIENT NAME:			PRESBRIBER NAME:
DATE OF BIRTH:		GENDER: M / F	SPECIALTY:
SSN:			ADDRESS:
ADDRESS:			
			PHONE:
PHONE:			FAX:
			DEA: NPI:
INSURANCE INFORMATION			**CURRENT PHARMACY INFORMATION**
INSURANCE PLAN NAME:			PHARMACY NAME:
RX BIN:	RX GROUP:		CITY, STATE:
ID:			PHONE:
MEDICARE ☐	MEDI-CAL ☐	COMMERCIAL ☐	FAX:

PRESCRIPTION INFORMATION

VASCEPA®
(icosapent ethyl)

☐ VASCEPA 1GM CAPSULES
DIRECTIONS: _Take 2 Capsules twice daily_____
QTY __# 120___REFILLS_____

CLINICAL INFORMATION

DIAGNOSIS	SELECT MEDICATIONS THE PATIENT HAS A
☐ **E78.1** PURE HYPERGLYCERIDEMIA	FAILURE, INTOLERANCE, CONTRAINDICATION:
☐ **E78.2** MIXED HYPERLIPIDEMIA	☐ **EPONOVA®** (OMEGA 3-CARBOXYLIC ACIDS)
☐ **E11** TYPE 2 DIABETES MELLITUS	☐ **LOVAZA®** (OMEGA-3-ACID ETHYL ESTERS)
IS THE MEDICATION BEING USED AS A CONTINUATION OF THERAPY? ☐ **YES** ☐ **NO**	☐ **OMTRYG®** **(**OMEGA-3-ACID ETHYL ESTERS A)
IS THE PATIENT ON A LIPID LOWERING DIET? ☐ **YES** ☐ **NO**	☐ **OMEGA 3 FISH OIL®** (DIETARY SUPPLEMENT)
IS THE MEDICATION BEING USED WITH STATIN THERAPY? ☐ **YES**☐ **NO**	☐ **TRICOR®** (FENOFIBRATE)
****TRIGLYCERIDE LEVEL**_____ **DATE**_____	**OTHER DIAGNOSIS**_____ **ICD 10 CODE**_____

PLEASE ATTACH COPY OF PRESCRIPTION, LABS, PROGRESS NOTES

SUPPORTING STATEMENT (COMMENTS, SYMPTOMS, AND WHY OTHER MEDICATIONS WOULD NOT BE APPROPRIATE)

_____
_____
_____
_____

By signing below, the prescriber gives consent to **Orange Plaza Pharmacy to act as the prescriber's agent** to begin and execute the prior authorization process, as well as to help the patient apply to co-pay assistant programs (including coupons, foundations and manufacturer assistance programs if necessary). The prescriber certifies that the information is true, accurate and the requested services are medically necessary to the health of the patient.

PRECRIBER SIGNATURE: _____**DATE:**_____ DO NOT SUBSTITUTE ☐

ORANGE PLAZA PHARMACY

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1010 W. La Veta Ave. Suite 130 Orange, CA 92868 **Fax: 714-550-9336**