BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 1/21/16**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

LOVAZA® (omega-3-acid ethyl esters) oral capsule
VASCEPA® (icosapent ethyl) oral capsule

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

LOVAZA® (omega-3-acid ethyl esters) oral capsule
VASCEPA® (icosapent ethyl) oral capsule (cont.)

Criteria:

- **Criteria for initial therapy:** Lovaza and Vascepa are considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual is 18 years of age or older
  2. A confirmed diagnosis of **hypertriglyceridemia (≥ 500 mg/dL)**
  3. Individual is compliant with a lipid-lowering diet and exercise program
  4. Failure, contraindication or intolerance to omega-3-acid ethyl esters (generic Lovaza)
  5. **For Vascepa only**:
     - Failure of another prescription Omega-3 fatty acid product has resulted in an increase in LDL-C (documentation of use of other product and that an increase has occurred is required and must be submitted with request)

  Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request):** Lovaza and Vascepa is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. The condition has not progressed or worsened while on therapy
  2. Triglyceride level is within the normal limits or has dropped at least by 50%
  3. Individual has been adherent with the medication, lipid-lowering diet, and exercise

  Renewal duration: 12 months

Description:

Lovaza and Vascepa are omega-3 fatty acids indicated as an adjunct to diet and exercise to reduce triglyceride levels in adults with severe (500 mg/dL or more) hypertriglyceridemia. The Endocrine Society guidelines for the treatment of hypertriglyceridemia recommends that omega-3 fatty acids may be considered for triglyceride levels greater than 1,000 mg/dL and may be used alone or in combination with HMG-CoA reductase inhibitors (or statin). Secondary causes of hyperlipidemia should be ruled out prior to therapy. The effect, if any, of omega-3 fatty acids on the risk of pancreatitis or cardiovascular mortality and morbidity in patients with severe hypertriglyceridemia is not known.

In general, omega-3 fatty acids are a mixture of eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA). Lovaza (brand & generic) omega-3 acid ethyl esters capsules contain at least 900 mg of ethyl esters of omega-3 fatty acids sourced from fish oil, which are predominantly EPA (approximately 465 mg) and DHA (approximately

LOVAZA® (omega-3-acid ethyl esters) oral capsule
VASCEPA® (icosapent ethyl) oral capsule (cont.)

375 mg). Epanova is a carboxylic acid free fatty acid composed of a combination of polyunsaturated fatty acids. It includes 50-60% EPA, 15-25% DHA, and other omega-3 fatty acids. Omtryg is an omega-3 fatty acid ethyl esters A containing ≥ 75% EPA and DHA. Icosapent ethyl is an ethyl ester of EPA obtained from fish oil; however, it contains at least 96% EPA and does not contain DHA.

Several clinical studies have demonstrated that icosapent ethyl and prescription omega-3 acid ethyl esters can effectively lower triglycerides, as well as positively impact other lipid parameters when used as monotherapy or in combination with fenofibrate or a statin.

Recommendations in clinical guidelines regarding the use of omega-3 fatty acids are varied. Older guidelines suggest omega-3 fatty acids may reduce the risk of cardiovascular disease and may be reasonable for cardiovascular disease risk reduction, while newer guidelines do not address the use or recommend against the use of omega-3 fatty acids for reducing the risk of cardiovascular disease due to limited data. In general, therapeutic lifestyle changes, including diet, exercise, and smoking cessation, remain an essential modality in the management of patients with hypercholesterolemia. When LDL lowering is required, initial treatment with a statin is recommended and considered first line therapy for patients with established coronary heart disease (CHD) or CHD equivalents.

The exact mechanism by which these agents reduce triglyceride levels is not completely understood. Possible mechanisms include: inhibition of acyl CoA: 1,2 diacylglycerol acyltransferase (DGAT), increased hepatic mitochondrial and hepatic peroxisomal beta-oxidation, reduction in the hepatic synthesis of triglycerides, or an increase in plasma lipoprotein lipase activity. They may also reduce the hepatic synthesis of triglycerides because EPA and DHA are poor substrates for the enzymes responsible for triglyceride synthesis, and EPA and DHA inhibit esterification of other fatty acids.

The majority of EPA circulating in plasma is incorporated in phospholipids, triglycerides and cholesteryl esters, and <1% is present as the unesterified fatty acid. Greater than 99% of unesterified EPA is bound to plasma proteins. Icosapent ethyl is de-esterified during absorption to its active metabolite EPA. EPA is mainly metabolized by the liver via beta-oxidation similar to dietary fatty acids. Beta oxidation splits the long carbon chain of EPA into acetyl Coenzyme A, which is converted into energy via the Krebs cycle. Cytochrome P450-mediated metabolism is a minor pathway of elimination of EPA.

Resources:

Lovaza. Package Insert. Reference ID LVZ:12PI. Revised by manufacturer 5/2014. Accessed 11-11-2015.

Vascepa. Package Insert. Reference ID PP00120G. Revised by manufacturer 1/2015. Accessed 11-11-2015.

Lovaza. Package Insert. Revised by manufacturer 09/2015. Accessed 12-07-2016, 07-19-2018.

Vascepa. Package Insert. Revised by manufacturer 09/2016. Accessed 12-07-2016.

Vascepa. Package Insert. Revised by manufacturer 02-2017. Accessed 07-19-2018.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.