

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ Provider ID Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information

Medication: _____ Quantity: _____ ICD-10 Code: _____

Directions: _____ Diagnosis: _____ Refills: _____

Physician Signature**: _____ DAW (Initial here): _____

Physician Signature:** By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? Yes No

Is this medication a **New Start**? Yes No

If **NO** please provide the following: _____ Initiation Date: / / _____ Date of Last Dose: / / _____

****Please attach any pertinent clinical information that would pertain to support stated diagnosis.**

Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed

Delivery Instructions

Note: Delivery coordination requires a **"Physician Signature"** above and complete **"Provider Information"** and **"Patient Information"**

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office Patient's Address Date medication is needed: / / _____

Medication Administered: Home Health Self Administered LTC Physician's Office

Low Molecular Weight Heparin

Preferred: Lovenox

Non-Preferred: Arixtra, Fragmin, Innohep

Prior Authorization Request Form

Complete ENTIRE form and Fax to 866-940-7328: PAGE 1 of 2

SECTION A – PATIENT INFORMATION						
First Name:		Last Name:		Member ID:		
Street Address:						
City:		State:		Zip:		
Phone:			Date of Birth:			
Does this patient have other / primary insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes please provide primary insurance information below)						
Primary Insurance:		Policy #:		Group #:		
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____						
Is this patient currently hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO						
SECTION B – PHYSICIAN INFORMATION						
First Name:			Last Name: D.O./M.D.			
Address		City:		State:		Zip:
Phone:		Fax:		NPI:		Specialty::
Office Contact Name:						
SECTION C – MEDICAL INFORMATION						
Medication Name & Strength:						
Directions for Use:						
If requesting Arixtra, Fragmin, or Innohep: Has the preferred product (Lovenox) failed to treat the patient's condition? (Check appropriate answer) <input type="checkbox"/> YES or <input type="checkbox"/> NO (if yes, provide details) _____						
What is the patient's diagnosis? (Check appropriate answer) Provide ICD 10 Code: _____						
<input type="checkbox"/> Hospital Discharge <input type="checkbox"/> Prophylaxis of DVT due to <input type="checkbox"/> Surgery – Type _____ <input type="checkbox"/> Restricted Mobility <input type="checkbox"/> Withholding Warfarin <input type="checkbox"/> Treatment or prevention of thromboembolic disease or VTE (DVT or PE) during pregnancy. Due Date: _____ <input type="checkbox"/> Does this patient have cancer? <input type="checkbox"/> YES or <input type="checkbox"/> NO (if yes, provide details) _____ <input type="checkbox"/> Other. List diagnosis: _____						
Is the patient undergoing one of the following?						
<input type="checkbox"/> Hip fracture surgery <input type="checkbox"/> Hip replacement surgery <input type="checkbox"/> Knee replacement surgery						
(Additional Questions on the next page)						

Please complete and return both pages of this request form along with the specialty cover sheet to avoid unnecessary delay.

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Is the requested medication being used for DVT Prophylaxis After Surgery YES or NO Type of surgery _____

If the patient had abdominal Surgery, is the patient at risk for thromboembolic complications YES or NO

Is the requested Medication being used as DVT or PE prophylaxis in patients with one of the following? YES or NO

(Check appropriate answers)

- Mechanical Heart Valve
- Atrial Fibrillation with history of Thromboembolic Stroke
- Recent History (within 3 months) of venous Thromboembolism
- due to recent Surgery or invasive Procedure

If the patient is using for Prophylaxis of VTE during Pregnancy does the patient have one of the following

- History of Prior VTE
- Mechanical Heart Valve
- Antiphospholipid Antibody (APLA) Syndrome and history of pregnancy Loss
- Thrombophilia and one of the following: Homozygous for the factor V Leiden mutation, Homozygous for the prothrombin G20210A mutation, Antithrombin deficiency
- Previously received Long term Coumadin anticoagulation treatment

Is the requested medication being prescribed for prophylaxis of ischemic complications in one of the following:

- Unstable Angina
- Non Q Wave Myocardial Infarction

Does the patient have a history of intolerance, failure or a contradiction to enoxaparin (lovenox)? YES or NO

If yes please list intolerance/failure: _____

Additional clinical information: _____

Please Note: The Plan provides up to a 14 day supply of enoxaparin at the point of sale without prior authorization every 90 days.

Physician Signature: _____

Date: _____

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