UnitedHealthcare Community Plan

**Prior Authorization Request Form**
**Fax Back To: (866) 940-7328**
**Phone: (800) 310-6826**

# 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 ☐

UnitedHealthcare Community Plan

# 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? ☐ YES ☐ NO *(if yes please provide primary insurance information below)*

| Primary Insurance: | Policy #: | Group #: |
|---|---|---|

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐YES ☐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) ☐ YES or ☐ NO (if yes, provide details) _____

What is the patient's diagnosis? (Check appropriate answer) Provide ICD 10 Code:_____

- ☐ Hospital Discharge
- ☐ Prophylaxis of DVT due to ☐ Surgery – Type_____ ☐ Restricted Mobility ☐ Withholding Warfarin
- ☐ Treatment or prevention of thromboembolic disease or VTE (DVT or PE) during pregnancy. Due Date: _____
- ☐ Does this patient have cancer? ☐ YES or ☐ NO (if yes, provide details) _____
- ☐ Other. List diagnosis:_____

Is the patient undergoing one of the following?

- ☐ Hip fracture surgery
- ☐ Hip replacement surgery
- ☐ 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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# Low Molecular Weight Heparin

## Preferred: Lovenox

## Non-Preferred: Arixtra, Fragmin, Innohep

## Prior Authorization Request Form



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 Fibrilation 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:_____ |
|---|---|

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



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