

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: <input type="checkbox"/> Male	<input type="checkbox"/> 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:	ICD10 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)					
<input type="checkbox"/> Acute ST-segment elevation myocardial infarction (STEMI). <input type="checkbox"/> Unstable angina/non-Q-wave myocardial infarction (MI). <input type="checkbox"/> Treatment or prevention of thromboembolic disease or VTE (DVT or PE) during pregnancy <input type="checkbox"/> Deep vein thrombosis (DVT) or Pulmonary Embolism (PE) <input type="checkbox"/> Other. List diagnosis: _____					
(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

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Prior Authorization Request Form

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If patient is pregnant list due date: _____

For non-pregnant patients: Which of the following best suits this request (check one only):

- Acute treatment (short-term anticoagulation needed)
- Long-term treatment (long term anticoagulation needed)
- Prevention of DVT or PE due to surgery / acute illness

Does this patient have cancer? YES or NO (if yes, provide details) _____

Is the requested medication being started along with warfarin (Coumadin), and then will be discontinued when INR is in therapeutic range? YES or NO

If no, why is Coumadin not a treatment option for this patient? (Check appropriate answer)

- Treatment with warfarin is contraindicated in this patient. List reason: _____
- Treatment with warfarin is not tolerated. List adverse events: _____
- Other (please explain): _____

For LONG TERM requests: For what reason is long term treatment with the requested medication needed? (Check appropriate answer)

- Recurrent DVT
- Recurrent PE
- Other (please explain): _____

For PREVENTION of DVT or PE due to surgery / acute illness: What type of prevention is the requested medication being used for? (Check appropriate answer)

- Knee arthroplasty (replacement)
- Hip arthroplasty (replacement)
- Status post-surgery (example: major general surgery, vascular surgery, gynecological surgery)
- DVT or PE prevention in cancer patients
- DVT or PE prevention in patients with severely restricted mobility during acute illness
- Other (please explain): _____

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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