pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTICOAGULANTS, INJECTABLE PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request**
- To review the prior authorization guidelines for Injectable Anticoagulants, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Anticoagulants** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request PA#:_____	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested

Preferred Agents		Non-Preferred Agents	
☐enoxaparin syringe*	☐Fragmin syringe	☐Arixtra syringe	☐Lovenox multi-dose vial
☐enoxaparin multi-dose vial	☐Fragmin multi-dose vial	☐fondaparinux syringe	☐Lovenox syringe

*(*Note: Enoxaparin syringes from the following manufacturers are NON-PREFERRED: Winthrop [00955-XXXX-XX] and APP [63323-XXXX-XX].)*

Strength:	Directions:	Quantity:	Duration of therapy:
Weight: lbs / kg	Diagnosis:		Dx code (required):

Section A: All non-preferred requests

1. Did the Recipient try and fail the preferred Injectable Anticoagulants? ☐enoxaparin ☐Fragmin	☐Yes – *submit all supporting documentation of drugs tried and treatment outcomes* ☐No
2. Does the Recipient have any contraindications or intolerances to the preferred agents listed in question (1)?	☐Yes – *submit all supporting documentation of contraindications and intolerances* ☐No

Section B: All requests for duration of therapy exceeding 10 days

1. Does the Recipient have a medical condition that requires therapy at the prescribed dose for more than 10 days?	☐Yes – *submit clinical documentation of medical condition requiring treatment for more than 10 days* ☐No
2. Is there medical literature to support the use of the prescribed dose and duration as a safe, effective, and widely-accepted medical practice for the Recipient's condition?	☐Yes – *submit medical literature supporting requested dose and duration of therapy* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: