Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Lovenox® (Enoxaparin)

BCBSVT and TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____

Member ID#:_____ Date of Birth: _____

Provider Name:_____ Provider Phone: _____

Provider Fax: _____ PCP Name: _____

Patient Weight: _____

INDICATIONS FOR USE: *(if this is a renewal proceed to question 8)*	YES	NO
1. Patient has undergone abdominal, hip, and/or knee replacement surgery **and** is at risk of thromboembolic complications: DVT and PE.	☐	☐
2. Patient's mobility is restricted during an acute illness (defined as a walking distance of <10 meters for ≤3 days).	☐	☐
3. Patient has unstable angina or non Q-wave myocardial infarction and is at risk for thromboembolic complications **only** when concurrently administered with aspirin.	☐	☐
4. Treatment of acute DVT with or without PE **only** when administered in conjunction with warfarin. [At least 5 days of overlap is necessary until the INR is therapeutic (2-3). Once INR is therapeutic an additional 2 days of overlap is recommended].	☐	☐
5. Patient is hemodynamically stable.	☐	☐
6. Patient's liver function tests are within normal limits (ALT 7-53 IU/L and AST 11-47 IU/L)	☐	☐
7. Patient is ≥ 18 years of age.	☐	☐
8. **If this is a renewal:** Has the patient demonstrated appropriate anticoagulation?	☐	☐

REASONS FOR BENEFIT DENIAL:	YES	NO
1. Patient is at risk of hemorrhage.	☐	☐
2. Has patient recently undergone neuroaxial anesthesia or spinal puncture (**Black Box Warning**).	☐	☐
3. Patient is thrombocytopenic (platelet count ≤100,000/mm^3).	☐	☐
4. Patient has a hypersensitivity to enoxaparin sodium, heparin, or pork products.	☐	☐
5. Individual is considered a low risk general/minor surgery patient <40 years of age with no additional risk factors.	☐	☐

If patient meets criteria: • <u>Initial approval</u>: 30 days and a quantity limit: 30 inj/30 days • <u>Renewal approval period</u>: 1 month

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE_____ DATE_____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.