

PRIOR AUTHORIZATION REQUEST Anticoagulants - Oral

TENT:	Name		Prescriber:	Name					
				AddressCity, State, Zip					
	City, State,								
				Phone					
	Member ID	:		Fax					
				NPI					
	Medica	ntion Requested:	Qty Red	quested:					
scribed a intities c on receip	a medication an be provion of of the con	n for your patient that require ded. Please complete the foll npleted form, prescription be	s Prior Authorization bet lowing questions then fa enefit coverage will be de	fore benefit coverage or coverage of additional x this form to the toll free number listed below betermined based on the plan's rules.					
SEC	TION A	Please answer the fo	ollowing questions	<u> </u>					
Is this	a request f	or INITIAL or CONTINUA	TION of therapy with	the requested medication?					
☐ IN	ITIAL → pi	lease proceed to question	2						
			estion 2 ONLY						
	· · · · · · · · · · · · · · · · · · ·								
Acute venous thromboembolism (VTE) Please note: this includes pulmonary embolism (PE) and									
				naa ranlaaamant					
			iii (v i E) aitei iiip oi k	пее теріасетіеті					
			hip or knee replacem	ent					
		, ,							
		-							
				eplacement AND document the date of					
		surgery:	•						
		Does the patient have r	moderate to high risk o	of stroke as demonstrated by FITHER a					
☐ Yes		(/							
	□ No	Does the patient have r	moderate to high risk (of stroke as demonstrated by TWO of the					
	□No	Does the patient have r		of stroke as demonstrated by TWO of the entricle ejection fraction (LVEF) of 35%					
		Does the patient have r following risk factors: 1 OR LESS; 2) hypertens) heart failure or left ve sion; 3) diabetes mellit	entricle ejection fraction (LVEF) of 35% cus; 4) 75 years of age OR OLDER?					
☐ Yes		Does the patient have refollowing risk factors: 1 OR LESS; 2) hypertens is this a request for a part of the patient have refore a patient) heart failure or left ve sion; 3) diabetes mellit	entricle ejection fraction (LVEF) of 35%					
	□No	Does the patient have refollowing risk factors: 1 OR LESS; 2) hypertens is this a request for a payorfarin?) heart failure or left ve sion; 3) diabetes mellit atient who has been υ	entricle ejection fraction (LVEF) of 35% cus; 4) 75 years of age OR OLDER? inable to achieve therapeutic INR on					
☐ Yes	□No	Does the patient have refollowing risk factors: 1 OR LESS; 2) hypertens is this a request for a payorfarin?) heart failure or left ve sion; 3) diabetes mellit atient who has been υ	entricle ejection fraction (LVEF) of 35% cus; 4) 75 years of age OR OLDER?					
	Ir patient scribed antities con receipt SEC Is this IN	Address:City, State, D.O.B Member ID Medica If patient's prescript scribed a medication antities can be provided in receipt of the constitution receipt of the constitution and Intitial Acute venous deep vein the Prevention on please and Venous thror All other indicated and All other indicated and Please specify when the please specific	Address: City, State, Zip D.O.B. Member ID: Medication Requested: It patient's prescription benefit requires that we scribed a medication for your patient that require antities can be provided. Please complete the folion receipt of the completed form, prescription be SECTION A Please answer the folion receipt of the completed form, prescription be INITIAL → please proceed to question INITIAL → please proceed to question CONTINUATON → please answer question CONTINUATON → please answer question Non-valvular atrial fibrillation → please Non-valvular atrial fibrillation → please Prevention of venous thromboembolism (VTE deep vein thrombosis (DVT) → please Prevention of venous thromboembolism (VTE) after All other indications and diagnoses (put) Please specify whether the patient is unde surgery. Date of surgery: HIP KNEE Yes No Does the patient have the history of systemic embers.	Address: City, State, Zip D.O.B. Member ID: Member ID: Medication Requested: Medication Requested: Member ID: Mether Indication Requestion 1 Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member Id: Mether Indication Requestion 1 Member Id: Member					

Continued on Page 2 Page 1 of 2

If you have any questions, call: 800-753-2851



PRIOR AUTHORIZATION REQUEST <u>Anticoagulants - Oral</u>

Continued from Page 1

Please document the diagnose	s, symptoms, ar	nd/or any other	rinformation im	portant to this	review:
SECTION B Physicia	n Signature				
OLOTION B IIIIysicia	<u>iii Oigilataic</u>				
PHYSICIAN :	SIGNATURE			DATE	

Page 2 of 2

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.