Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
ANTI-THROMBOTIC INJECTABLES

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 10 consecutive days. Prior authorization will be required for all non-preferred anti-thrombotic agents beginning the first day of therapy. Payment for usage beyond this limit will be granted on an individual basis upon review of medical necessity.

Preferred (PA required after 10 days)		**Non-Preferred** (PA required from Day 1)	
Arixtra	☐	Innohep	☐
Fragmin	☐	Other (specify)_____	☐
Lovenox	☐		

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:

- ❑ **Pregnancy or planned pregnancy**
- ❑ **Cancer-associated thromboembolic disease**
- ❑ **Anti-thrombin III deficiency**
- ❑ **Warfarin allergy**
- ❑ **History of thrombotic event while on therapeutic anticoagulant therapy**
- ❑ **Other (please specify)_____**

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

Other medical conditions to consider:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.