Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

ENOXAPARIN

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Will the total duration of enoxaparin use exceed 180 out of 365 days? Please provide intended duration of therapy (Please note: prior authorization is not required for less than or equal to 180 days of enoxaparin therapy every 365 days.)

☐ Yes ☐ No

Q2. Is enoxaparin being used for venous thromboembolism (VTE) treatment or prophylaxis in the setting of pregnancy, cancer, or age less than 18 years? Please provide diagnosis.

☐ Yes ☐ No

Q3. Does the patient have another diagnosis for which medical literature would support enoxaparin as the treatment of choice over oral anticoagulants, or has the patient had an inadequate response or adverse reaction to oral anticoagulant therapy (including a novel oral anticoagulant [NOAC], or warfarin if NOAC use is not supported by literature)? Please provide diagnosis and documentation of agent(s) used, with dose, dates/duration of use, and specific outcomes.

☐ Yes ☐ No

Q4. Is enoxaparin being used at a dose and duration consistent with prescribing information, consensus guidelines and/or current medical practice?

☐ Yes ☐ No

Q5. Requested Duration:

☐ 12 Months

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Patient Name:	**Prescriber Name:**

Q6. Additional Information:

Prescriber Signature

Date

Updated 2018

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