PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Lovenox - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Lovenox - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Enoxaparin Lovenox (enoxaparin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Has documentation been submitted which supports a continual medical necessity for use? Y N _____

[Note: Documentation must be submitted.]

	[No further questions.]	
3.	Is the patient actively bleeding?	Y N
	[If yes, then no further questions.]	
4.	Does the patient have a positive heparin induced thrombocytopenia (HIT) assay?	Y N
	[If yes, then no further questions.]	
5.	Does the patient have any known allergy or severe adverse reaction (ADR) to enoxaparin or any of its components?	Y N
	[If yes, then no further questions.]	
6.	Is the requested drug being prescribed for any of the following: A) Oncology patients with risk factors for venous thromboembolism (VTE), B) Abdominal-Pelvic surgery patients at high risk for venous thromboembolism (VTE), C) Total hip arthroplasty, D) Total knee arthroplasty, E) Hip fracture surgery, F) Deep vein thrombosis (DVT) treatment, G) Pulmonary embolism (PE) treatment, H) Superficial vein thrombosis treatment, I) Atrial Fibrillation (AF) patients undergoing cardioversion, J) Acute ischemic stroke and immobility, K) Pregnant & lactating women at high risk for venous thromboembolism (VTE) or recurrent venous thromboembolism (VTE), L) Children and infants with venous thromboembolism (VTE) or increased risk?	Y N
	[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date