



Prior Authorization Request Form for Anticoagulants

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermyeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:	Member Name:		
Prescriber Specialty:	Identification #:		
NPI:	Group #:		
Office Contact Name:	Date of Birth:		
Fax #:	Medication Allergies:		
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Does the member have a history of a contraindication to the requested medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Anticoagulants? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes Medications Taken Previously (start and end date and dose): _____ <input type="checkbox"/> No _____		
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. another Anticoagulant or dose different from the agent being requested):			
<input type="checkbox"/> For oral anticoagulant, the member is the being titrated to or tapered from another oral anticoagulant <input type="checkbox"/> For injectable anticoagulant, the member is being titrated to or tapered from another injectable anticoagulant <input type="checkbox"/> Has a clinical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence: _____			
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :			
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:	

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)