Prior Authorization Form

Lovenox Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lovenox Post Limit.

Drug Name (select from list of drugs shown)
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.	Does the patient have any of the following contraindications: Active major bleeding, Thrombocytopenia?	Y N
2.	Does the patient have a diagnosis of cancer with a risk of thrombosis?	Y N
	[If the answer to this question is yes, then no further questions required.]	
3.	Does the patient have the diagnosis of unstable angina or non-ST segment elevation (non-Q wave) myocardial infarction?	Y N
	[If the answer to this question is no, then skip to question 6.]	

4.	Is or will the patient also be taking aspirin?	Y N
	[If the answer to this question is yes, then no further questions required.]	
5.	Is aspirin contraindicated?	Y N
	[No further questions required.]	
6.	Is Lovenox being requested for the PROPHYLAXIS or TREATMENT of thrombotic complications in a high risk pregnancy (i.e., congenital thrombophilia, antiphospholipid antibodies, prosthetic heart valve or previous pregnancy complications)? [NOTE: Please provide patient's estimated due date.	Y N
	The duration of approval is based on the due date of the pregnancy plus 6 weeks.]	
	[If the answer to this question is yes, then no further questions required.]	
7.	Is Lovenox being requested for the PROPHYLAXIS of venous thromboembolism (VTE) (i.e., deep vein thrombosis (DVT) and/or pulmonary embolism (PE))?	Y N
	[If the answer to this question is yes, then no further questions required.]	
8.	Is Lovenox being requested for the TREATMENT of venous thromboembolism (VTE) (i.e., deep vein thrombosis (DVT) and/or pulmonary embolism (PE))?	Y N
	[If the answer to this question is no, then skip to question 11.]	
9.	Is or will the patient also be taking an oral anticoagulant (i.e., Coumadin or warfarin)?	Y N
	[If the answer to this question is yes, then no further questions required.]	
10.	Are oral anticoagulant therapies (i.e., Coumadin or warfarin) contraindicated?	Y N
	[No further questions required.]	
11.	Is Lovenox being requested for bridge therapy due to high risk for thromboembolism (e.g., mechanical heart valves, atrial fibrillation or VTE)?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date