

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

**PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM**

A request for the patient identified below has been made for the dispensing of anticoagulants. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: check all that apply)			
<p>1. What is the requested medication?</p> <p> <input type="checkbox"/> Arixtra (fondaparinux)                      <input type="checkbox"/> Lovenox (enoxaparin)                      <input type="checkbox"/> Heparin  <input type="checkbox"/> Fragmin (dalteparin)                      <input type="checkbox"/> Innohep (tinzaparin) </p> <p>2. What is the indication for the requested drug?</p> <p> <input type="checkbox"/> DVT Prophylaxis                      <input type="checkbox"/> DVT Treatment  <input type="checkbox"/> Abdominal Surgery                      <input type="checkbox"/> Unstable Angina/Non-Q-wave  <input type="checkbox"/> Hip Replacement Surgery                      <input type="checkbox"/> Immobility/Acute Illness  <input type="checkbox"/> Knee Replacement Surgery                      <input type="checkbox"/> Other _____ </p> <p>3. Please indicate the following:</p> <p>DOSE: _____ FREQUENCY: _____</p> <p>DURATION OF THERAPY: _____ WEIGHT: _____</p> <p style="text-align: center;"><b>If treatment is required beyond <u>21 days</u>, please provide chart documentation.</b></p>			
<b>Authorized Medical Signature:</b>			
Telephone:		Date:	

**When Completed Return To:**

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507  
1-866-965-Drug (3784) / Fax # 866-999-7736

\*\*Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.