PRIOR AUTHORIZATION for PROTHROMBIN TIME (INR) HOME TESTING DEVICES

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

***Ordering* Provider:**			***Ordering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

***Rendering* Provider:**			***Rendering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: ***Please check.***

☐ Auth Extension ☐ Date of Service Change ☐ Place of Service Change ☐ Pre-Auth ☐ Code Change ☐ Provider Change ☐ Retro Auth ☐ Urgent

Requested Date(s) of Service: **From:** **To:**	**Primary Diagnosis/ICD-10 Code:**	**Secondary Diagnosis/ICD-10 Code:**

Are services related to a motor vehicle accident? ☐ Yes ☐ No

Date of Accident: _____

Are services related to a work-related injury? ☐ Yes ☐ No

Date of Injury: _____

Durable Medical Equipment (DME) Requested: ***Please check Purchase, Rental, or Repair/Replacement. Unlisted codes cannot be pre-authorized.***

DME Description: _____ HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Repair/Replacement

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QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient require chronic anticoagulation with Warfarin (Coumadin)?	☐	☐	
2. Does the patient require chronic anticoagulation for any of the following conditions? ***Please check.*** ☐ Chronic Atrial Fibrillation (AFIB) ☐ Deep Venous Thrombosis ☐ Hypercoagulable State (e.g., Antithrombin III Deficiency, Factor V Leiden, Protein C Deficiency, and Protein S Deficiency, etc.) ☐ Mechanical Heart Valve ☐ Pulmonary Embolism (PE) ☐ Venous Embolism and Thrombosis of Deep Vessels of the Lower Extremity ☐ Ventricular Assist Device (VAD)	☐	☐	
3. Is the expected need for home INR testing six (6) months or longer?	☐	☐	
4. Has the member been anticoagulated for at least three (3) months prior to initiating home INR testing?	☐	☐	
5. Does the member lack reasonable access to office-based or laboratory-based INR testing due to factors such as geographic distance, limited transportation, mobility restrictions, or medical conditions that make frequent in-person testing impractical?	☐	☐	
6. Are target-specific oral anticoagulants/direct oral anticoagulants (TSOACs/DOACs), such as apixaban (Eliquis), dabigatran (Pradaxa), rivaroxaban (Xarelto), or edoxaban (Savaysa), contraindicated for the patient?	☐	☐	
7. Is self-testing required more than once per week?	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.