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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

For a complete list of available pre-authorization forms, please go to **https://www.pehp.org/providers/preauthforms.**

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:	Ordering Provider/Physician:	Ordering Provider/Physician NPI #:

Ordering Provider/Physician Contact Person:	Phone: ( )	Facsimile: ( )

Rendering Provider/Physician:	Rendering Provider/Physician NPI #:	Rendering Provider/Physician Contact Person:	Rendering Provider/Physician Phone: ( )

Facility Name:	Facility NPI #:	Facility Tax ID #:	Facility Address:

Facility Contact Person:	Phone: ( )	Facsimile: ( )

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:	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.*

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 / Thrombosis of Deep Vessels of Lower Extremity ☐ 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 ☐ Ventricular Assist Device (VAD)	☐	☐	
3. Will home INR testing be needed for 6 months or longer?	☐	☐	
4. Has the patient been anticoagulated for at least the past three months?	☐	☐	
5. Does the patient lack reasonable access to the office or lab-based testing?	☐	☐	
6. Is the use of target-specific oral anticoagulants, including direct thrombin inhibitors (e.g., dabigatran/Pradaxa) and direct factor Xa inhibitors (e.g., rivaroxaban/Xarelto, apixaban/Eliquis, edoxaban/Savaysa), contraindicated for the patient?	☐	☐	
7. Will the patient need to self-test with the device only once per week?	☐	☐	
8. Is prothrombin time home testing unit being requested for any of the following conditions? *Please check.* ☐ Arterial Embolism to the Eye ☐ Atrial Flutter ☐ Kawasaki Disease	☐	☐	

Additional Comments:

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