Direct Oral Anticoagulants Drugs
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or the Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is not required for preferred direct oral anticoagulants (DOACs). Prior authorization is required for non-preferred DOACs. Requests will be considered for FDA approved dosing and length of therapy for submitted diagnosis. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications for the requested drug under the following conditions:

1) Patient is within the FDA labeled age for indication; and
2) Patient does not have a mechanical heart valve; and
3) Patient does not have active bleeding; and

4) For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA2DS2-VASc score ≥ 1; and
5) A recent creatinine clearance (CrCl) is provided; and
6) A recent Child-Pugh score is provided; and
7) Patient's current body weight is provided; and
8) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred DOACs; and
9) For requests for edoxaban, when prescribed for the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE), documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) is provided. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred (no PA required if within established quantity limits)

☐ Eliquis ☐ Xarelto

☐ Pradaxa

Non-Preferred (PA required)

☐ Bevyxxa

☐ Savaysa

Does patient have mechanical heart valve? ☐ Yes ☐ No

Does patient have active bleeding? ☐ Yes ☐ No

Patient body weight:_____ **Date obtained:** _____

Provide recent creatinine clearance (CrCl): _____ **Date obtained:** _____

Provide recent Child-Pugh score: _____ **Date completed:** _____

Requests for a diagnosis of atrial fibrillation or stroke prevention:

Risk factor based CHA2DS2-VASc Score	
Risk Factors	**Score**
□ Congestive heart failure	1
□ Hypertension	1
□ Age ≥ 75 years	2
□ Age between 65 and 74 years	1
□ Stroke / TIA / TE	2
□ Vascular disease (previous MI, peripheral arterial disease or aortic plaque)	1
□ Diabetes mellitus	1
□ Female	1
Total	

Document 2 preferred DOAC trials:

Preferred DOAC Trial 1: Name/dose: _____ Trial dates: _____

Failure reason:_____

Preferred DOAC Trial 2: Name/dose: _____ Trial dates: _____

Failure reason:_____

Requests for edoxaban (Savaysa):
Provide documentation of 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) for diagnosis of DVT or PE:

Drug name and dose: _____ Trial dates: _____

Medical or contraindication reason to override trial requirements: _____
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.