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Novel Oral Anticoagulants 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.
Provider Help Desk: 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 novel oral anticoagulants (NOACs). PA is required for nonpreferred NOACs. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications under the following conditions:

1. Patient does not have a mechanical heart valve.
2. Patient does not have active bleeding.
3. For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least 1 additional risk factor for stroke, with a CHA_2DS_2-VASc score ≥1.
4. A recent creatinine clearance (CrCl) is provided.
5. A recent Child-Pugh score is provided.
6. Patient's current body weight is provided.
7. Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred NOACs.
8. For requests for edoxaban, documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin). 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

Nonpreferred
☐ Savaysa

Diagnosis: ____

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 CHA_2DS_2-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 NOAC trials
Preferred NOAC Trial 1:
Name/dose: _______________________________________ Trial dates: ______________________________
Failure reason: ____

Preferred NOAC Trial 2:
Name/dose: _______________________________________ Trial dates: ______________________________
Failure reason: ____

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