https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Savaysa (edoxaban)

Prior Authorization of Benefits (PAB) Form

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**
Savaysa (edoxaban)	____________	____________	Specify: ____________

7. DIAGNOSIS: ____________________________

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Patient body weight:____________________ Date obtained:____________

Provide recent creatinine clearance (CrCl):____________________ Date obtained:____________

Provide recent Child-Pugh score:____________________ Date completed: ____________

□ Yes □ No Patient has a mechanical prosthetic heart valve

□ Yes □ No Patient has active pathological bleeding

□ Yes □ No Patient has a diagnosis of atrial fibrillation or stroke prevention **If Yes:**

- □ Yes □ No Patient has the presence of at least one additional risk factor for stroke, with a CHA2DS2-VASc score =1

□ Yes □ No Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred novel oral anticoagulants (NOACs) (the preferred NOACs are: Pradaxa and Xarelto) **If No:**

- □ Yes □ No Documentation* has been provided with this request of evidence that the use of The preferred agents would be medically contraindicated

□ Yes □ No Documentation* is provided that the patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin)

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

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Patient Name: ________________________________ **Patient ID#:** ________________________________

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	1
☐ Diabetes mellitus	1
☐ Female	1
Total	

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.

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