Request for Prior Authorization
Direct oral anticoagulants

Contains confidential patient information
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at **844-512-9004**.
Provider Help Desk: **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
☐ Xarelto Suspension
☐ Savaysa
☐ Dabigatran

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 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 & 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

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.