PRIOR AUTHORIZATION REQUEST
Anticoagulants – Oral – Non Formulary

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested: _____ **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
- ❑ INITIAL → ***please answer questions 2 - 9***
- ❑ CONTINUATON → ***please answer question 10***

2 ❑ Yes ❑ No Has the patient tried and failed therapy with Eliquis?

3 What is the indication or diagnosis?
- ❑ Non-valvular atrial fibrillation
- ❑ Acute venous thromboembolism (VTE)
- ❑ Prevention of venous thromboembolism (VTE) after hip or knee replacement
  Please document the date of surgery._____
- ❑ All other indications and diagnoses ***(Please specify):***_____

4 Is the patient undergoing HIP or KNEE replacement?
- ❑ HIP
- ❑ KNEE

5 ❑ Yes ❑ No Does the patient have moderate to high risk of stroke as demonstrated by EITHER a history of systemic embolism OR a history of stroke or transient ischemic attack (TIA)?

6 ❑ Yes ❑ No Does the patient have moderate to high risk of stroke as demonstrated by TWO of the following risk factors: 1) heart failure or left ventricle ejection fraction (LVEF) of 35% OR LESS; 2) hypertension; 3) diabetes mellitus; 4) 75 years of age OR OLDER?

7 ❑ Yes ❑ No Is this a request for a patient who has been unable to achieve therapeutic INR on warfarin?

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If you have any questions, call: 800-753-2851

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8. ❑ Yes ❑ No Is this a request for a patient who has been unable to take warfarin due to potential drug interaction?
9. ❑ Yes ❑ No Has the patient been stabilized on their current medication?
10. What is the indication or diagnosis?
    - ❑ Acute venous thromboembolism (VTE)
    - ❑ Venous thromboembolism (VTE) after hip or knee replacement
    - ❑ Non-valvular atrial fibrillation
    - ❑ All other indications and diagnoses ***(Please specify):*** _____

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 800-753-2851