PRIOR AUTHORIZATION REQUEST
Anticoagulants - Oral

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 proceed to question 2***
   - ❑ CONTINUATON → ***please answer question 2 ONLY***
2. What is the indication or diagnosis?
   - ❑ Non-valvular atrial fibrillation → ***please answer questions 4-5***
   - ❑ Acute venous thromboembolism (VTE) -- Please note: this includes pulmonary embolism (PE) and deep vein thrombosis (DVT) → ***please answer questions 6-8***
   - ❑ Prevention of venous thromboembolism (VTE) after hip or knee replacement → ***please answer question 3***
   - ❑ Venous thromboembolism (VTE) after hip or knee replacement
   - ❑ All other indications and diagnoses ***(please specify):***_____

3. Please specify whether the patient is undergoing HIP or KNEE replacement AND document the date of surgery. ***Date of surgery:_____.***
   - ❑ HIP
   - ❑ KNEE

4. ❑ 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)?
5. ❑ 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?
6. ❑ Yes ❑No Is this a request for a patient who has been unable to achieve therapeutic INR on warfarin?
7. ❑ Yes ❑No Is this a request for a patient who has been unable to take warfarin due to potential drug interaction?
8. ❑ Yes ❑No Has the patient been stabilized on their current medication?

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

MARYLAND physicians care
MANAGED CARE ORGANIZATION

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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

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