PRIOR AUTHORIZATION REQUEST
Platelet Inhibitors

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?
   - θ INITIAL → ***please answer questions 2 - 18***
   - θ CONTINUATION → ***please answer question 19 - 20***
2. What is the indication or diagnosis?
   - θ Acute coronary syndrome (ACS) (for example, unstable angina, SEMI, NSTEMI)
   - θ All other indications

If the prescribed drug is **Effient,** please answer questions 3 - 8

3.	θ Yes	θ No	Has the patient tried and failed OR has a contraindication/intolerance to clopidogrel?
4.	θ Yes	θ No	Is the patient a poor CYP2C19 metabolizer?
5.	θ Yes	θ No	Does the patient have active pathological bleeding, history of intracranial hemorrhage, or planned CABG?
6.	θ Yes	θ No	Is the patient considered a high thromboembolic risk?
7.	θ Yes	θ No	Is the patient taking concomitant 75-325mg/day aspirin?
8.	θ Yes	θ No	Does the patient have a history of TIA or stroke?

If the prescribed drug is **Brilinta*,*** please answer questions 9 - 13

9.	θ Yes	θ No	Has the patient tried and failed OR has a contraindication or intolerance to clopidogrel?
10.	θ Yes	θ No	Does the patient have an active pathological bleeding, history of intracranial hemorrhage, or planned coronary artery bypass graft (CABG)?
11.	θ Yes	θ No	Is the patient taking concomitant 75-100mg/day aspirin?
12.	θ Yes	θ No	Does the patient have a severe hepatic impairment?
13.	θ Yes	θ No	Does the patient have a concomitant use with medications known to interact with Brilinta (for example, potent CYP3A4 inhibitors/inducers and simvastation or lovastatin in doses GREATER THAN 40mg/day)?

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

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If the prescribed drug is **Zontivity,** please answer questions 14 - 18

14.	θ Yes	θ No	Is the requested medication being prescribed for a patient with peripheral artery disease (PAD) or history myocardial infarction (MI)?
15.	θ Yes	θ No	Is the requested medication being used with aspirin and/or clopidogrel according to the standard of care for the patient's diagnosis?
16.	θ Yes	θ No	Does the patient have an active pathological bleeding?
17.	θ Yes	θ No	Does the patient have a history of stroke, transient ischemic attack (TIA), or intracranial hemorrhage (ICH)?
18.	θ Yes	θ No	Does the patient have a concomitant use with potent CYP3A4 inhibitors or inducers?

If the prescribed drug is **Effient** or **Brilinta,** please answer question 19
If the prescribed drug is **Zontivity**, please answer question 20

19.	θ Yes	θ No	Does the patient have a history of stent restenosis?
20.	θ Yes	θ No	Is this a request for Zontivity for a patient with peripheral artery disease (PAD) or a history of MI (myocardial infarction)?

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

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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