PRIOR AUTHORIZATION REQUEST

Oral Anticoagulants- Eliquis

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient currently receiving Eliquis? [If no, skip to question 5.]	Yes	No
2	Has the patient been receiving medication samples of Eliquis? [If yes, skip to question 5.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for Eliquis? [Note: If the patient does NOT have a previously approved PA on file for the	Yes	No

If you have any questions, call: 1-888-258-8250

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	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 5.]		
4	Has documentation been submitted to confirm that the patient has experienced a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
5	What is the indication or diagnosis? [] Atrial fibrillation (or atrial flutter) (If checked, no further questions) [] Prophylaxis of deep vein thrombosis in a patient undergoing hip or knee replacement surgery (If checked, no further questions) [] Treatment or prevention of other thromboembolic-related conditions. Note: Examples of other thromboembolic-related conditions include superficial vein thrombosis, splanchnic vein thrombosis, hepatic vein thrombosis, or prophylaxis of venous thromboembolism in a high-risk patient. (If checked, go to 6) [] Treatment of deep vein thrombosis or pulmonary embolism (If checked, go to 8) [] To reduce the risk of recurrence of deep vein thrombosis or pulmonary embolism (If checked, go to 10) [] Prophylaxis of venous thromboembolism in an acutely ill medical patient. Note: This includes post- discharge thromboprophylaxis for a patient hospitalized with coronavirus disease 19 (COVID-19). (If checked, no further questions) [] Other (If checked, no further questions)		
6	Has the patient been started on the requested medication for the treatment of an acute thromboembolic condition? [If yes, no further questions.]	Yes	No
7	Has the patient tried warfarin, fondaparinux, or a low molecular weight heparin product (for example, enoxaparin, Fragmin)? [No further questions.]	Yes	No
8	Has the patient been diagnosed with their first deep vein thrombosis or pulmonary embolism? [If yes, no further questions.]	Yes	No
9	Has the patient been diagnosed with recurrent deep vein thrombosis or pulmonary embolism? [If yes, no further questions.]	Yes	No
10	Has the patient been diagnosed with a condition that predisposes them to deep vein thrombosis or pulmonary embolism recurrence? If yes, please provide the	Yes	No

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patient's diagnosis: _____.

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: 1-833-896-0656

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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Version 07.2025