PRIOR AUTHORIZATION REQUEST

Platelet Inhibitors – Effient/Brilinta/Zontivity

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 this request for INITIAL or CONTINUATION of therapy with the requested medication?
[] Initial (If checked, go to 2)
[] Continuation (If checked, go to 24)

2 What is the requested medication?
[] Effient (If checked, go to 3)

[] Brilinta (If checked, go to 11)

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Version 07.2025

PRIOR AUTHORIZATION REQUEST

	[] Zontivity (If checked, go to 19) [] Other (If checked, no further questions)		
3	What is the indication or diagnosis? [] Acute coronary syndrome (ACS) (for example, unstable angina, SEMI, NSTEMI) (If checked, go to 4) [] Other (If checked, no further questions)		
4	Has the patient tried and failed OR has a contraindication or intolerance to clopidogrel? [If yes, skip to question 6.]	Yes	No
5	Is the patient a poor CYP2C19 metabolizer? [If no, no further questions.]	Yes	No
6	Does the patient have active pathological bleeding, history of intracranial hemorrhage, or planned coronary artery bypass graft (CABG)? [If yes, no further questions.]	Yes	No
7	Is the patient LESS THAN 75 years of age? [If yes, skip to question 9.]	Yes	No
8	Is the patient considered a high thromboembolic risk? [If no, no further questions.]	Yes	No
9	Is the patient currently taking 75mg to 325mg of aspirin per day? [If no, no further questions.]	Yes	No
10	Does the patient have a history of transient ischemic attack (TIA) or stroke? [If yes, no further questions.] [If no, skip to question 18.]	Yes	No
11	What is the indication or diagnosis? [] Acute coronary syndrome (ACS) (for example, unstable angina, SEMI, NSTEMI) (If checked, go to 12) [] Other (If checked, no further questions)		
12	Has the patient tried and failed OR has a contraindication or intolerance to clopidogrel? [If yes, skip to question 14.]	Yes	No
13	Is the patient a poor CYP2C19 metabolizer? [If no, no further questions.]	Yes	No
14	Does the patient have active pathological bleeding, history of intracranial hemorrhage, or planned coronary artery bypass graft (CABG)?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If yes, no further questions.]		
15	Is the patient currently taking 75mg to 100mg of aspirin per day? [If no, no further questions.]	Yes	No
16	Does the patient have a severe hepatic impairment? [If yes, no further questions.]	Yes	No
17	Is the patient currently taking medications known to interact with Brilinta (for example, potent CYP3A4 inhibitors/inducers and simvastatin or lovastatin in doses GREATER THAN 40mg/day)? [If yes, no further questions.]	Yes	No
18	Does the patient have a history of stent thrombosis or restenosis? [No further questions.]	Yes	No
19	Is the requested medication being prescribed for the secondary prevention of atherothrombosis in patients with peripheral artery disease (PAD) or history of myocardial infarction (MI)? [NOTE: Zontivity is not indicated for (ACS).] [If no, no further questions.]	Yes	No
20	Is the requested medication being used with aspirin and/or clopidogrel according to the standard of care for the patient's diagnosis? [If no, no further questions.]	Yes	No
21	Does the patient have active pathological bleeding? [If yes, no further questions.]	Yes	No
22	Does the patient have a history of stroke, transient ischemic attack (TIA), or intracranial hemorrhage (ICH)? [If yes, no further questions.]	Yes	No
23	Is the patient currently taking a potent CYP3A4 inhibitor or inducer? [No further questions.]	Yes	No
24	What is the requested medication? [] Effient (If checked, go to 25) [] Brilinta (If checked, go to 25) [] Zontivity (If checked, no further questions)		
25	Does the patient have a history of stent thrombosis or restenosis?	Yes	No

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Version 07.2025

PRIOR AUTHORIZATION REQUEST

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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