PRIOR AUTHORIZATION REQUEST

Pradaxa

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	Does the patient have active pathological bleeding? [If yes, no further questions.]	Yes	No
2	Does the patient have mechanical prosthetic heart valve? [If yes, no further questions.]	Yes	No
3	What is the indication or diagnosis? [] Atrial fibrillation (or atrial flutter) (If checked, go to 4) [] Treatment of first deep vein thrombosis or pulmonary embolism (DVT/PE) diagnosis (If checked, go to 5)		

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

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[] Treatment of deep vein thrombosis or pulmonary embolism (DVT/PE) to reduce the risk of recurrence (If checked, go to 6)

[] Prevention of deep vein thrombosis or pulmonary embolism (DVT/PE) in a patient undergoing hip replacement surgery (If checked, go to 9)

[] Prevention of deep vein thrombosis (DVT) in a patient undergoing knee replacement surgery (If checked, go to 9)

[] Treatment or prevention of other thromboembolic-related conditions (If checked, go to 10)

[] Prevention of venous thromboembolism in an acutely ill medical patient (If checked, no further questions)

[] Other (If checked, no further questions)

4	Is the patient greater than or equal to 18 year(s) of age? [No further questions.]	Yes	No
5	Is the patient greater than or equal to 8 year(s) of age? [No further questions.]	Yes	No
6	Is the patient greater than or equal to 8 year(s) of age? [If no, no further questions.]	Yes	No
7	Does the provider attest that the patient has experienced another/recurrent DVT/PE? [If yes, no further questions.]	Yes	No
8	Does the provider attest that the patient has a high-risk recurrence factor or diagnosis? If yes, please provide the patient's diagnosis and/or risk factor:_____ [No further questions.]	Yes	No
9	Is the patient greater than or equal to 18 year(s) of age? [No further questions.]	Yes	No
10	Is the patient greater than or equal to 8 year(s) of age? [If no, no further questions.]	Yes	No
11	Has the patient tried Eliquis (apixaban tablets), Xarelto (rivaroxaban tablets), or Savaysa (edoxaban tablets)? [If yes, no further questions.]	Yes	No
12	Has the patient tried warfarin, fondaparinux, or a low molecular weight heparin product (for example, enoxaparin, Fragmin [dalteparin injection])? [If yes, no further questions.]		

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13	Has the patient been started on dabigatran capsules for the treatment of an acute thromboembolic condition?	Yes	No

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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