



PRIOR AUTHORIZATION REQUEST

XARELTO

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 the requested medication? [If no, skip to question 10.]	Yes	No
2	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan?	Yes	No

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questions, call:
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[NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]

[If no, skip to question 10.]

- 4 What is the diagnosis or indication?
- Atrial fibrillation (or atrial flutter) (If checked, go to 5)
 - Coronary artery disease (If checked, go to 5)
 - Prevention of deep vein thrombosis in a patient undergoing knee or hip replacement surgery (If checked, no further questions)
 - Treatment of first deep vein thrombosis (DVT) or pulmonary embolism (PE) (If checked, go to 5)
 - Reduce risk of recurrence of deep vein thrombosis (DVT) or pulmonary embolism (PE) (If checked, go to 5)
 - Peripheral Artery Disease (PAD) (If checked, go to 5)
 - Thromboprophylaxis in a patient with congenital heart disease (If checked, go to 5)
 - Prevention of venous thromboembolism (VTE) 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)
 - 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 7)
 - Other (If checked, no further questions)
- 5 Has the patient been on established therapy for at least 3 months? Yes No
[If no, skip to question 10.]
- 6 Does the patient have a Creatinine Clearance (CrCl) GREATER THAN OR EQUAL TO 15 mL/min? Yes No
[If yes, skip to question 8.]
[If no, no further questions.]
- 7 Has the patient been on established therapy for at least 6 months? Yes No
[If no, skip to question 10.]
- 8 Has documentation been submitted to confirm that there is a beneficial clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment? Yes No
ACTION REQUIRED: Submit supporting documentation.
[No further questions.]

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9	<p>Has documentation been submitted to confirm that there is a beneficial clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]</p>	Yes	No
10	<p>What is the diagnosis or indication? <input type="checkbox"/> Atrial fibrillation (or atrial flutter) (If checked, go to 11) <input type="checkbox"/> Coronary artery disease (If checked, go to 22) <input type="checkbox"/> Prevention of deep vein thrombosis in a patient undergoing knee or hip replacement surgery (If checked, go to 31) <input type="checkbox"/> Treatment of first deep vein thrombosis (DVT) or pulmonary embolism (PE) (If checked, go to 37) <input type="checkbox"/> Reduce risk of recurrence of deep vein thrombosis (DVT) or pulmonary embolism (PE) (If checked, go to 43) <input type="checkbox"/> Peripheral Artery Disease (PAD) (If checked, go to 48) <input type="checkbox"/> Thromboprophylaxis in a patient with congenital heart disease (If checked, go to 60) <input type="checkbox"/> Prevention of venous thromboembolism (VTE) in an acutely ill medical patient. Note: This includes post-discharge thromboprophylaxis for a patient hospitalized with coronavirus disease 19 (COVID-19). (If checked, go to 65) <input type="checkbox"/> 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 70) <input type="checkbox"/> Other (If checked, no further questions)</p>		
11	<p>Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]</p>	Yes	No
12	<p>Does the patient have a documented diagnosis of nonvalvular atrial fibrillation? [If no, no further questions.]</p>	Yes	No
13	<p>Has documentation been submitted to confirm that the patient has previous trial and failure with Eliquis and dabigatran for MORE THAN 30 days unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]</p>	Yes	No
14	<p>Does the patient have an active pathological bleed? [If yes, no further questions.]</p>	Yes	No
15	<p>Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [If no, no further questions.]</p>	Yes	No
16	<p>Does the patient have an artificial heart valve?</p>	Yes	No

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[If yes, no further questions.]

17	Does the patient have moderate to severe mitral stenosis? [If yes, no further questions.]	Yes	No
18	What is the patient's gender? <input type="checkbox"/> Male (males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression) (If checked, go to 19) <input type="checkbox"/> Female (females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression) (If checked, go to 20)		
19	Does the prescriber attest that the patient has a moderate to high risk for stroke with a CHA2DS2-VASc score of GREATER THAN OR EQUAL TO 2? [If yes, skip to question 21.] [If no, no further questions.]	Yes	No
20	Does the prescriber attest that the patient has a moderate to high risk for stroke with a CHA2DS2-VASc score of GREATER THAN OR EQUAL TO 3? [If no, no further questions.]	Yes	No
21	Does the requested daily dosage exceed 20mg? [No further questions.]	Yes	No
22	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
23	Will the patient be taking concomitant aspirin at least 75mg daily? [If no, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that the patient has atherosclerosis or revascularization involving 2 vascular beds? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Does the patient have 2 or more of the following: A) Current smoker (within the last year); (B) Diabetes mellitus; C) Heart failure; D) Non-lacunar ischemic stroke at least 30 days ago; E) Renal impairment (CrCl LESS THAN 60 mL/min)? [If no, no further questions.]	Yes	No
26	Does the provider attest that the patient has not had a recent non-lacunar stroke within 30 days of starting therapy? [If no, no further questions.]	Yes	No
27	Does the provider attest that the patient does not have a history of hemorrhagic or lacunar stroke? [If no, no further questions.]	Yes	No
28	Does the provider attest that the patient does not require dual antiplatelet in combination with anticoagulants therapy? [If no, no further questions.]	Yes	No

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29	Does the provider attest that the patient has a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [If no, no further questions.]	Yes	No
30	Does the requested daily dosage exceed 10mg? [No further questions.]	Yes	No
31	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
32	Does the provider attest that the patient has a scheduled hip or knee replacement surgery? If yes, please provide the date of the patient's procedure: _____. [If no, no further questions.]	Yes	No
33	Has documentation been submitted to confirm that the patient has previous trial and failure with Eliquis and dabigatran unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [If no, no further questions.]	Yes	No
35	Does the daily dosage exceed 10mg? [If yes, no further questions.]	Yes	No
36	Is the request for DVT prevention in knee surgery or hip replacement surgery? <input type="checkbox"/> Knee surgery (If checked, no further questions) <input type="checkbox"/> Hip replacement surgery (If checked, no further questions)		
37	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
38	Does the patient have a new documented diagnosis of deep vein thrombosis or pulmonary embolism? [If no, no further questions.]	Yes	No
39	Has documentation been submitted to confirm that the patient has a treatment failure with Eliquis and dabigatran for MORE THAN 30 days unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
40	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [If no, no further questions.]	Yes	No
41	Does the patient have an active pathological bleed? [If yes, no further questions.]	Yes	No
42	Does the requested daily dosage exceed 20mg? [No further questions.]	Yes	No

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43	Does the provider attest that the patient has experienced another/recurrent DVT/PE? [If yes, skip to question 45.]	Yes	No
44	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: _____ [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has trial and failure with Eliquis and dabigatran unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [If no, no further questions.]	Yes	No
47	Does the requested daily dosage exceed 10mg? [No further questions.]	Yes	No
48	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
49	Does the provider attest that the patient has a history or moderate to severe PAD? [If no, no further questions.]	Yes	No
50	Does the patient have a history of a successful peripheral surgical procedure and/or endovascular procedure with or without clopidogrel used for a maximum of 6 months? [If no, no further questions.]	Yes	No
51	Does the patient have a prior history of limb revascularization? [If no, skip to question 53.]	Yes	No
52	Does the patient have a post-revascularization ankle brachial index LESS THAN OR EQUAL TO 0.85? [If yes, skip to question 54.] [If no, no further questions.]	Yes	No
53	Does the patient have an ankle brachial index LESS THAN OR EQUAL TO 0.80? [If no, no further questions.]	Yes	No
54	Does the provider attest that the patient does not require GREATER THAN 6 months of dual antiplatelet therapy? [If no, no further questions.]	Yes	No
55	Does the provider attest that the patient does not require additional antiplatelet therapy or oral anticoagulants? [If no, no further questions.]	Yes	No
56	Does the provider attest that the patient does not have a history of Transient Ischemic Attacks (TIA), stroke, or intracranial hemorrhage? [If no, no further questions.]	Yes	No
57	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min?	Yes	No

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[If no, no further questions.]		
58	Will the patient be taking concomitant aspirin at least 75 mg daily? [If no, no further questions.]	Yes No
59	Does the requested daily dosage exceed 5mg? [No further questions.]	Yes No
60	How old is the patient? <input type="checkbox"/> Greater than or equal to 2 years of age and Less than 18 years of age (If checked, go to 61) <input type="checkbox"/> Other (If checked, no further questions)	
61	Has documentation been submitted to confirm that the patient has undergone the Fontan procedure? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes No
62	What drug is being requested? <input type="checkbox"/> Xarelto TABLET, Xarelto TABLET, DOSE PACK (If checked, no further questions) <input type="checkbox"/> Xarelto SUSPENSION, RECONSTITUTED, ORAL (ML) (If checked, go to 63)	Yes No
63	Is the patient unable to have Xarelto tablets appropriately administered? [If yes, no further questions.]	Yes No
64	Can the prescribed Xarelto dose be achieved by Xarelto 2.5mg, 10 mg, 15 mg, or 20 mg tablets? [No further questions.]	Yes No
65	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes No
66	Does the provider attest that the patient is at risk for VTE when the patient experiences prolonged immobilization? [If yes, skip to question 68.]	Yes No
67	Does the provider attest that the patient is at risk for VTE with a history of ONE or more of the following: A) Cancer, B) VTE, C) Heart failure, D) Thrombophilia, E) Acute infectious disease, F) Body Mass Index (BMI) GREATER THAN OR EQUAL TO 35 kg/m2? [If no, no further questions.]	Yes No
68	Was the patient hospitalized for at least ONE of the following: A) Heart failure, B) Active cancer, C) Acute ischemic stroke, D) Acute infectious disease, E) Inflammatory disease, F) Acute respiratory insufficiency? [If no, no further questions.]	Yes No
69	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min? [No further questions.]	Yes No
70	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes No

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71	Has documentation been submitted to confirm that the patient had a previous trial and failure with Eliquis and dabigatran unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
72	Does the patient have a CrCl GREATER THAN OR EQUAL TO 15 mL/min?	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.

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