PRIOR AUTHORIZATION REQUEST

SAVAYSA

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 therapy or for a continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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

PRIOR AUTHORIZATION REQUEST

	[If yes, skip to question 7.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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 7.]	Yes	No
5	Has the patient been on established therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	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. [No further questions.]	Yes	No
7	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
8	What is the diagnosis or indication? [] Nonvalvular atrial fibrillation (NVAF) (If checked, go to 9) [] Treatment of deep vein thrombosis or pulmonary embolism (If checked, go to 11) [] 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, no further questions) [] Other (If checked, no further questions)		
9	Does the patient have a documented diagnosis of nonvalvular atrial fibrillation (NVAF)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the patient have an estimated creatinine clearance LESS THAN OR EQUAL TO 95 ml/min within the last 90 days? [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
11	Does the member have a documented diagnosis of deep vein thrombosis or pulmonary embolism? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has received 5 to 10 days of initial therapy with a parenteral anticoagulant prior to initiating the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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

Version 05.2026

PRIOR AUTHORIZATION REQUEST

13	Has documentation been submitted to confirm that the patient has had a previous trial and failure with Eliquis and dabigatran for at least 30 days unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Does the patient have an active pathological bleed? [If yes, no further questions.]	Yes	No
15	Has the patient been evaluated for significant drug interactions with other anticoagulants, antiplatelets, thrombolytics, serotonin norepinephrine reuptake inhibitors (SNRI), selective serotonin reuptake inhibitors (SSRI), rifampin, etc.? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed FDA approved label dosing for the requested indication? Note: Dosing: treatment of DVT/PE - 60 mg once daily or treatment of NVAF 30 mg or 60 mg once daily.	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.

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