



Request for Prior Authorization
NOVEL ORAL ANTICOAGULANTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is not required for preferred novel oral anticoagulants (NOACs). Prior authorization is required for non-preferred NOACs. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications under the following conditions: 1) Patient does not have a mechanical heart valve; and 2) Patient does not have active bleeding; and 3) For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA2DS2-VASc score >=1; and 4) A recent creatinine clearance (CrCl) is provided; and 5) A recent Child-Pugh score is provided; and 6) Patient's current body weight is provided; and 7) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred NOACs. 8) For requests for edoxaban, documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred (no PA required if within established quantity limits)

Non-Preferred (PA required)

- Eliquis, Xarelto, Pradaxa

- Savaysa

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Does patient have mechanical heart valve? Yes No

Does patient have active bleeding? Yes No

Patient body weight: Date obtained:

Provide recent creatinine clearance (CrCl): Date obtained:

Provide recent Child-Pugh score: Date completed:

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**Requests for a diagnosis of atrial fibrillation or stroke prevention:**

Risk factor based CHA <sub>2</sub> DS <sub>2</sub> -VASc Score	
Risk Factors	Score
<input type="checkbox"/> Congestive heart failure	1
<input type="checkbox"/> Hypertension	1
<input type="checkbox"/> Age ≥ 75 years	2
<input type="checkbox"/> Age between 65 and 74 years	1
<input type="checkbox"/> Stroke / TIA / TE	2
<input type="checkbox"/> Vascular disease (previous MI, peripheral arterial disease or aortic plaque)	1
<input type="checkbox"/> Diabetes mellitus	1
<input type="checkbox"/> Female	1
<b>Total</b>	

**Document 2 preferred NOAC trials:**

Preferred NOAC Trial 1: Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Preferred NOAC Trial 2: Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Requests for edoxaban (Savaysa):**

Provide documentation of 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin):

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*