

**Request for Prior Authorization
DIRECT ORAL ANTICOAGULANTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name 	DOB
Patient address 		
Provider NPI 	Prescriber name 	Phone
Prescriber address 		Fax
Pharmacy name 	Address 	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax 	NDC

Prior authorization (PA) is not required for preferred direct oral anticoagulants (DOACs). Prior authorization is required for non-preferred DOACs. Requests will be considered for FDA approved dosing and length of therapy for submitted diagnosis. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications for the requested drug under the following conditions: 1) Patient is within the FDA labeled age for indication; and 2) Patient does not have a mechanical heart valve; and 3) Patient does not have active bleeding; and 4) 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 5) A recent creatinine clearance (CrCl) is provided; and 6) A recent Child-Pugh score is provided; and 7) Patient's current body weight is provided; and 8) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred DOACs; and 9) For requests for edoxaban, when prescribed for the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE), documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) is provided. 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)

- ☐ Eliquis ☐ Xarelto
☐ Pradaxa

Non-Preferred (PA required)

- ☐ Bevyxxa
☐ 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: _____

**Request for Prior Authorization
DIRECT ORAL ANTICOAGULANTS****Provider Help Desk**
1.866.399.0928

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Requests for a diagnosis of atrial fibrillation or stroke prevention:

Risk factor based CHA ₂ DS ₂ -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
Total	

Document 2 preferred DOAC trials:

Preferred DOAC Trial 1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred DOAC 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) for diagnosis of DVT or PE:

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.