iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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 CHA_2DS_2-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 Capsules

Non-Preferred (PA required)

- ☐ Bevyxxa
- ☐ Savaysa
- ☐ Dabigatran
- ☐ Xarelto Suspension
- ☐ Pradaxa Oral Packet

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_2DS_2-VASc Score	
Risk Factors	**Score**
☐ Congestive heart failure	1
☐ Hypertension	1
☐ Age ≥ 75 years	2
☐ Age between 65 and 74 years	1
☐ Stroke / TIA / TE	2
☐ Vascular disease (previous MI, peripheral arterial disease or aortic plaque)	1
☐ Diabetes mellitus	1
☐ 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

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 Health and Human Services, that the member continues to be eligible for Medicaid.*