PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Eliquis® (apixaban)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Eliquis 2.5 mg tablet ☐ Eliquis 5 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

1. Patient was started on Eliquis therapy in the hospital and was discharged while on the therapy **OR**
2. Diagnosis of non-valvular atrial fibrillation (NVAF) at moderate to high risk of stroke and systemic embolism, DVT prophylaxis in patients undergoing knee or hip replacement surgery, or for the treatment of DVT, pulmonary embolism (PE) and for the reduction in the risk of recurrence of DVT and PE.
    a. Trial and failure of warfarin

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. Patient was started on Eliquis therapy in the hospital and was discharged while on the therapy?

☐ Yes
☐ No: See next question.

B. What condition is this drug being requested for?

☐ Non-valvular atrial fibrillation
☐ Treatment of DVT or PE
☐ Prophylaxis of DVT
☐ Prevention of recurrence of DVT or PE
☐ Other: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018
Last reviewed 05/2019

C. Has the patient had a trial and failure with warfarin?

- ☐ Yes Dates:_____
- ☐ No: Rationale:_____

D. For diagnosis of non-valvular atrial fibrillation only, which of the following apply to this patient?

- ☐ History of stroke, TIA, or systemic embolism

OR (must be at least two of the following)

- ☐ Heart failure or LVEF ≤ 35%
- ☐ Hypertension
- ☐ ≥ 75 years old
- ☐ Diabetes mellitus

E. For prophylaxis of DVT only, which of the following apply to this patient?

- ☐ Hip Replacement surgery (35 days recommended)
- ☐ Knee Replacement surgery (12 days recommended)

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Last reviewed 05/2019