PriorityHealth

Medicaid Pharmacy Prior Authorization Form

Fax completed form to: 877-974-4411 toll free, or 616-942-8206

Xarelto® (rivaroxaban)

Patient Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Prescriber Information

Prescriber Name: _____ Phone: _____ Fax: _____

Prescriber Address: _____

Prescriber NPI: _____ Office Contact Name: _____

Prescriber Signature: _____ Date: _____

Product Information

Requested Drug:

- ☐ Xarelto 10mg
- ☐ Xarelto 15mg
- ☐ Xarelto 20mg

Requested dose: _____

Requested frequency: _____

Clinical Documentation

A. This request is for:

- ☐ New therapy
- ☐ Continuation of therapy

When did the patient first start using this medication? _____

B. What diagnosis is this drug being requested for? _____

C. What medications has the patient previously used for this condition?

Drug	Dose	Dates	Clinical Outcome

D. Supporting Information:

_____

_____

_____

_____

_____

_____

_____

All fields must be complete and legible for review. Your office will receive a response via fax.

Last reviewed 07/2020

Xarelto Drug Policy

Criteria contained in this policy only applies to drugs covered on the Priority Health Medicaid formulary. Before coverage of the requested medication is approved, all the following requirements must be met. Documentation supporting the following criteria must be included with this request.

Approved Diagnosis:
- Non-valvular atrial fibrillation (NVAF) at risk of stroke and systemic embolism
- DVT prophylaxis in patients undergoing knee or hip replacement surgery
- Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE)
- Reduction in the risk of recurrence of deep vein thrombosis (DVT) or pulmonary embolism (PE)
- Venous thromboembolism prophylaxis in acutely ill medical patients - Prophylaxis of venous thromboembolism (VTE) and VTE-related death during hospitalization and post hospital discharge in adults admitted for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE and not at high risk of bleeding.

Approval Timeframe:
- Initial authorization:
  - DVT prophylaxis for knee replacement: 12 days
  - DVT prophylaxis for hip replacement: 35 days
  - All other diagnosis: 12 months
- Continuation authorization:
  - DVT prophylaxis for knee replacement: N/A
  - DVT prophylaxis for hip replacement: N/A
  - All other diagnosis: 12 months

Prescriber Specialty Requirement: none

Age Limitation: Patient must be age 18 years or older

Initial Criteria:

Non-Valvular Atrial Fibrillation
- Must have documented trial and failure, or intolerance to, warfarin
- Must have moderate-to-high risk for stroke as determined by one the following:
  - Patient has history of stroke, TIA, or non-CNS systemic embolism, OR
  - Patient has TWO or more of the following risk factors:
    - Age ≥ 75 years old
    - Arterial hypertension requiring treatment
    - Diabetes Mellitus
    - Heart failure ≥ NYHA Class II
    - Left ventricular Ejection Fracture ≤ 40%

DVT prophylaxis in patient undergoing knee or hip replacement surgery
- Must have undergone a:
  - Total hip arthroplasty, *OR*
  - Total knee arthroplasty

Treatment or Prevention of Recurrence of DVT or PE
- Must have previously experienced a DVT or PE
- Must have documented trial and failure, or intolerance to, warfarin

Continuation Criteria:
- Documentation showing the patient has experienced a positive response to therapy must be submitted
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Additional Information
- If the patient was established on rivaroxaban therapy while in the hospital, and was discharged while on therapy, the initial criteria does not apply.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

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.

All fields must be complete and legible for review. Your office will receive a response via fax. Last reviewed 07/2020