



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Anticoagulant and Antiplatelet Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

Anticoagulants Eliquis (apixaban) Eliquis (apixaban starter pack) Iprivask (desirudin)
 Pradaxa (dabigatran) Savaysa (edoxaban) Xarelto (rivaroxaban)
 Xarelto (rivaroxaban starter pack)

Antiplatelets Brilinta (ticagrelor) Durlaza (aspirin extended-release) prasugrel
 Yosprala (aspirin/omeprazole) Zontivity (vorapaxar)

Dose and frequency requested _____ **Duration of therapy requested** _____

Indication

- | | |
|--|---|
| <input type="checkbox"/> Non-ST elevation myocardial infarction
<input type="checkbox"/> Nonvalvular atrial fibrillation
<input type="checkbox"/> Peripheral artery disease
<input type="checkbox"/> Prophylaxis of:
<input type="checkbox"/> Deep vein thrombosis (DVT)
<input type="checkbox"/> Pulmonary embolism (PE)
Patient undergoing surgery:
<input type="checkbox"/> Total hip replacement
<input type="checkbox"/> Total knee replacement
<input type="checkbox"/> Reduce the risk of death and myocardial infarction in patients with chronic coronary artery disease | <input type="checkbox"/> Reduce the risk of recurrence of DVT and PE
<input type="checkbox"/> Reduce the risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack
<input type="checkbox"/> Secondary prevention of cardiovascular and cerebrovascular events with risk of developing aspirin associated gastric ulcers
<input type="checkbox"/> ST elevation myocardial infarction
<input type="checkbox"/> Treatment of deep vein thrombosis/pulmonary embolism
<input type="checkbox"/> Unstable angina
<input type="checkbox"/> Other _____ |
|--|---|

Section I. Please complete for Eliquis (except for use in prophylaxis of DVT after hip or knee replacement surgery), Pradaxa 75 mg and 150 mg, Savaysa, Xarelto 15 and 20 mg, and Xarelto Starter Pack requests.

1. Has the member experienced an inadequate response, adverse reaction, or contraindication to warfarin therapy?
 Yes. Please describe. _____

 No. Please explain why the member is not a candidate for warfarin therapy. _____

2. Is there a medical necessity for anticoagulation that does not require INR monitoring?
 Yes. Please explain. _____ No.
3. For Eliquis 2.5 mg tablets and Pradaxa 150 mg capsules for reduction in the risk of recurrence of DVT and PE, has the member just completed treatment for DVT or PE with a newer oral anticoagulant agent (NOAC)?
 Yes. Please explain. _____ No.

Section II. Please complete for Xarelto 10 mg at doses > 10 mg/day and > 35 units/365 days and for Pradaxa 110 mg > 70 units/365 days.

1. Is the member undergoing a second knee replacement surgery within 365 days? Yes. No.
2. Is the member undergoing a second hip replacement surgery within 365 days? Yes. No.
3. For Xarelto 10 mg, is the member concomitantly taking Xarelto with a P-glycoprotein or a strong CYP3A4 inducer?
 Yes. Please explain. _____ No.
4. For Xarelto 10 mg for reduction in the risk of recurrence of DVT and PE, has the member just completed treatment for DVT or PE with a newer oral anticoagulant agent (NOAC)?
 Yes. Please explain. _____ No.

Section III. Please complete for Brilinta requests.

1. Has the member been started and stabilized on the requested medication in the hospital?
 Yes. Please document date when therapy was initiated. _____ No.
2. Has the member experienced an inadequate response, adverse reaction, or contraindication to clopidogrel?
 Yes. Please describe. _____
 No. Please explain why the member is not a candidate for clopidogrel therapy.

3. If the member is a candidate for concurrent aspirin therapy, is the dose \leq 100 mg/day?
 Yes. No. If no, please explain. _____

Section IV. Please complete for prasugrel requests.

1. Does the member have a history of percutaneous coronary intervention (PCI)? Yes. No.
2. Has the member been started and stabilized on the requested medication in the hospital?
 Yes. Please document date when therapy was initiated. _____ No.
3. Has the member experienced an inadequate response, adverse reaction, or contraindication to clopidogrel?
 Yes. Please describe. _____
 No. Please explain why the member is not a candidate for clopidogrel therapy.

4. Is the member receiving concurrent aspirin therapy? Yes. Dose _____ Frequency _____
 No. Please explain. _____

Section V. Please complete for Iprivask requests.

1. Has the member experienced an inadequate response, adverse reaction, or contraindication to warfarin therapy?
 Yes. Please describe. _____
 No. Please explain why the member is not a candidate for warfarin therapy.

2. Has the member experienced an inadequate response, adverse reaction, or contraindication to fondaparinux?
 Yes. Please describe. _____
 No. Please explain why the member is not a candidate for fondaparinux therapy.

3. Has the member experienced an inadequate response, adverse reaction, or contraindication to a Low Molecular Weight Heparin (LMWH) product?
 Yes. Please describe. _____
 No. Please explain why the member is not a candidate for LMWH therapy.

4. Does the member have a history of heparin-induced thrombocytopenia (HIT) or thrombosis syndrome (HITTS)?
 Yes. Please describe. _____ No.

Section VI. Please complete for Zontivity requests.

1. Does the member have a history of stroke or transient ischemic attack? Yes. No.
2. Is the member receiving concurrent aspirin and/or clopidogrel therapy?
 Yes. Drug _____ Dose _____ Frequency _____ No.

Section VII. Please complete for Durlaza requests.

1. Has the member experienced an inadequate response or adverse reaction to aspirin?
 Yes. Please describe. _____ No.
2. Is there a medical necessity for an extended-release formulation?
 Yes. Please explain. _____ No.

Section VIII. Please complete for Yosprala requests.

Please provide compelling clinical rationale for why the combination aspirin/omeprazole would offer a therapeutic advantage over the individual agents.

Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____