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

Antiplatelets

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

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

Indication for Anticoagulant

- ☐ Nonvalvular atrial fibrillation
- ☐ Prophylaxis of:
  - ☐ Deep vein thrombosis (DVT)
  - ☐ Pulmonary embolism (PE)

  Patient undergoing surgery:
  - ☐ Total hip replacement
  - ☐ Total knee replacement
- ☐ Reduce the risk of major cardiovascular (CV) events in coronary artery disease (CAD)/peripheral artery disease (PAD)
- ☐ Reduce the risk of recurrence of DVT and PE
- ☐ Treatment of DVT
- ☐ Treatment of PE
- ☐ Other _____

Indication for Antiplatelet

- ☐ Non-ST elevation myocardial infarction (MI)
- ☐ PAD
- ☐ Reduce the risk of death and MI in patients with chronic CAD
- ☐ Secondary prevention to reduce the risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack
- ☐ Secondary prevention of CV and cerebrovascular events with risk of developing aspirin-associated gastric ulcers
- ☐ ST elevation MI
- ☐ Unstable angina
- ☐ 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, and Savaysa 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 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

Section III. Please complete for Xarelto 2.5 mg requests.

1. Does the member have a concomitant diagnosis of atrial fibrillation or venous thromboembolic disease?
   ☐ Yes. Please specify diagnosis. _____ ☐ No
2. Has the member been started and stabilized on the requested medication?
   ☐ Yes. Please document date when therapy was initiated. _____ Dose _____ Frequency _____
   ☐ No
3. Is the member receiving concurrent aspirin therapy?
   ☐ Yes. Drug _____ Dose _____ Frequency _____ ☐ No

Section IV. 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 ≤ 100 mg/day?
   ☐ Yes ☐ No. If no, please explain. _____

Section V. 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. _____

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Section VI. 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 VII. 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 VIII. 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 IX. 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 X. 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.

_____
_____
_____

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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 _____