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

Print Clear

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

- ☐ Iprivask (desirudin)
- ☐ Pradaxa (dabigatran)
- ☐ Savaysa (edoxaban)
- ☐ Xarelto (rivaroxaban)

Antiplatelets

- ☐ 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
- ☐ 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
- ☐ ST elevation MI
- ☐ Other _____

Section I. Please complete for 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 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.

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 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 V. 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

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Section VI. 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 _____