OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Savaysa**® (edoxaban) ***(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA: The following criteria MUST be met to qualify or authorization process will be delayed.

- ❑ Diagnosis of:
  - ❑ Non-valvular Atrial Fibrillation,

    OR
  - ❑ Deep vein thrombosis,

    OR
  - ❑ Pulmonary embolism,

    AND
- ❑ Documentation that CrC1 is ***NOT*** ≥ 95mL/min calculated by Cockcroft-Gault equation

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Revised/Updated: 7/1/2018**