OPTIMA HEALTH PLAN

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 form will delay authorization process.***

Drug Requested: **Eliquis®** (apixaban)

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***: ____________________

Renal and Hepatic Dosing Adjustments:

Patient height__________ **weight**_______ **serum creatinine**_________ **Patient Age**________

CLINICAL CRITERIA: Boxes MUST be checked below to qualify or authorization process will be delayed.

❑ **Patient is not using warfarin concomitantly**	
Choose *one Indication* below **AND**	**Choose *one Dosage* below**
❑ Nonvalvular atrial fibrillation(to prevent stroke and systemic embolism History of prosthetic heart valve ❑ Yes ❑ No Mitral Valve Disease ❑ Yes ❑ No	❑ 5 mg twice daily ❑ 2.5 mg twice daily (having 2 of the following: Age >/= 80 years, body weight </= 60kg or serum creatinine >/= 1.5)
OR	
❑ Postoperative venous thromboprophylaxis	❑ Hip replacement 2.5 mg twice daily: 35 days
	❑ Knee replacement 2.5 mg twice daily: 12 days
❑ Deep Vein Thrombosis ❑ Deep Vein Thrombosis, Recurrence	❑ 10 mg twice daily for 7 days, followed by 5 mg twice daily ❑ Prophylaxis: 2.5 mg twice daily following a minimum of 6 months of treatment for DVT
❑ Pulmonary Embolism ❑ Pulmonary Embolism, Recurrence	❑ 10 mg twice daily for 7 days, followed by 5 mg twice daily ❑ Prophylaxis: 2.5 mg twice daily following a minimum of 6 months of treatment for PE

*****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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: 4/18/2013
Revised/Updated: ~~7/9/2013; 4/8/2014; 5/8/2014; 9/22/2014; 10/30/2014; 5/21/2015; 12/27/2015~~; ~~12/16/2016~~; ~~1/6/2017~~; ~~1/9/2017~~; **9/19/2017**;