

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: Xarelto® (rivaroxaban)

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 (Scr): _____

Creatinine clearance (CrCl): _____

CLINICAL CRITERIA: ALL appropriate boxes MUST be checked to qualify or authorization process will be delayed.

<input type="checkbox"/> Patient is not using warfarin concomitantly	
AND	
Choose <u>one Indication</u> below	Choose <u>one Dosage</u> below
<input type="checkbox"/> Reduction of stroke and systemic embolism for patients with non-valvular atrial fibrillation	<input type="checkbox"/> 20mg daily for CrCl > 50mL/min
	<input type="checkbox"/> 15mg daily for CrCl 15-50mL/min
	<input type="checkbox"/> CrCl < 15ml/min (contraindication)
OR	
Diagnosis / Date: _____	
<input type="checkbox"/> Treatment of DVT/PE	<input type="checkbox"/> 15mg twice a day with food for 21days, then 20mg daily for 6 months
<input type="checkbox"/> CrCl > 30mL/min	
<input type="checkbox"/> CrCl < 30mL/min (contraindication)	
OR	
Diagnosis / Date: _____	
<input type="checkbox"/> Prevent recurrence of DVT/PE	<input type="checkbox"/> 20mg daily with food for up to 12 months
<input type="checkbox"/> CrCl > 30mL/min	
<input type="checkbox"/> CrCl < 30mL/min (contraindication)	
OR	
<input type="checkbox"/> Prophylaxis of DVT	<input type="checkbox"/> Hip replacement 10mg daily x 35 days
<input type="checkbox"/> CrCl > 30mL/min	<input type="checkbox"/> Knee replacement 10mg daily x 12 days
<input type="checkbox"/> CrCl < 30mL/min (contraindication)	

****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: 7/19/2012

Revised/Updated: 12/4/2012; 1/28/2013; 2/25/2013; 7/19/2013; 11/6/2014; 4/17/2015; 5/22/2015; 12/24/2015; 12/20/2016; 4/6/2017; 9/24/2017