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)

Sentara Quality Care Network Physicians are NOT required to submit a request

***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;~~ **8/12/2017**