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: **Pradaxa®** (dabigatran etexilate)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

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

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

Renal Dosing Adjustments*:** ***Creatinine Clearance will be calculated for patients >70 years old.

Age: _____ **Height:** _____ **Weight:** _____ **Scr:** _____

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

❑ Patient is not using warfarin concomitantly	
AND	
❑ Patient has tried and failed Xarelto® or Eliquis®	
AND	
Choose *one Indication* below: **AND**	**Choose *one Dosage* Below:**
❑ Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation History of prosthetic heart valve ❑ Yes ❑ No Mitral Valve Disease ❑ Yes ❑ No	❑ **150 mg** Twice Daily ❑ **75 mg** Twice Daily: for CrCl 15 to 30 ml/minute
OR	
❑ Treatment and Reduction in the Risk of Recurrence of DVT and PE	❑ **150 mg** Twice Daily after 5 – 10 days of parental anticoagulation ***(For Patients with CrCl > 30 ml/min)***
❑ Prophylaxis DVT/PE	❑ Hip Replacement: **110 mg** 1st day- then **220mg** daily – minimum of 10 to 14 days: duration can be up to 35 days

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**: 10/21/2010

UPDATED/REVISED: ~~4/1/2011; 6/14/2011; 8/18/2011; 3/20/2012; 5/8//2014; 9/23/2014; 11/2/2014; 5/22/2015; 12/28/2015; 1/26/2016; 12/19/2016; 8/16/2017;~~ **11/24/2017**