# 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® | |
| **AND** | |
| **Choose *one Indication* below:** **AND** | **Choose *one Dosage* Below:** |
| ❑ Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation<br>History of prosthetic heart valve ❑ Yes ❑ No<br>Mitral Valve Disease ❑ Yes ❑ No | ❑ **150 mg** Twice Daily<br>❑ **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**