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)

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 (Scr): __________________ **Creatinine clearance (CrCl):** __________________

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

❑ **Patient is not using warfarin concomitantly**	
AND	
Choose *one Indication* below **AND**	**Choose *one Dosage* below**
❑ Reduction of stroke and systemic embolism for patients with non-valvular atrial fibrillation	❑ 20mg daily for CrCl> 50mL/min ❑ 15mg daily for CrCl 15-50mL/min ❑ CrCl <15ml/min (contraindication)
OR	
Diagnosis / Date:__________________ ❑ Treatment of DVT/PE ❑ CrCl > 30mL/min ❑ CrCl < 30mL/min (contraindication)	❑ 15mg twice a day with food for 21days, then 20mg daily for 6 montl
OR	
Diagnosis / Date:__________________ ❑ Prevent recurrence of DVT/PE ❑ CrCl > 30mL/min ❑ CrCl < 30mL/min (contraindication)	❑ 20mg daily with food for up to 12 months
OR	
❑ Prophylaxis of DVT ❑ CrCl > 30mL/min ❑ CrCl < 30mL/min (contraindication)	❑ Hip replacement 10mg daily x 35 days ❑ Knee replacement 10mg daily x 12 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**: 7/19/2012
Revised/Updated: ~~12/19/2012; 1/28/2013; 2/25/2013; 7/19/2013; 11/6/2014; 4/17/2015; 5/22/2015; 12/24/2015; 12/20/2016;~~ **8/21/2017**;