pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ELIQUIS (apixaban) (preferred) PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Anticoagulants** and **Quantity Limits/Daily Dose Limits,** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request PA# _____		# of pgs in request: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:		Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Eliquis tablet	Strength: ☐2.5 mg	☐5 mg	☐_____
Directions:	Quantity:	Refills:	Recipient's weight: _____ lbs/kg

1. What is the Recipient's diagnosis? *Check below and document diagnosis code.* **Acute treatment:** ☐deep vein thrombosis (DVT) ☐pulmonary embolism (PE) **Long-term prophylaxis due to:** ☐atrial fibrillation (non-valvular) ☐history of DVT or PE **Post-op DVT prophylaxis:** ☐hip replacement - surgery date: _____ ☐knee replacement - surgery date: _____ **Diagnosis codes *(required for all diagnoses)*:** _____	*Submit medical record documentation supporting the Recipient's diagnosis.*
2. Does the Recipient have any of the following medical conditions? *Check all that apply.* ☐active pathological bleeding ☐biological or mechanical prosthetic heart valve ☐severe liver impairment	☐Yes – *Submit documentation.* ☐No
3. Does the Recipient have results of a recent serum creatinine (SCr) level?	☐Yes – *submit documentation of date of test and result* ☐No
4. Is the Recipient taking any of the following medications that may interact with Eliquis? *Check all that apply.* ☐A medication that may increase the risk of bleeding ☐anticoagulant (ex. warfarin, Pradaxa, Savaysa, Xarelto, heparin, enoxaparin, etc.) ☐antiplatelet agent (ex. Brilinta, Effient, clopidogrel/Plavix, dipyridamole, etc.) ☐aspirin ☐NSAID (ex. ibuprofen, naproxen, diclofenac (oral), etc.) ☐A medication that is a strong dual inducer of CYP3A4 and P-glycoprotein (P-gp) ☐carbamazepine ☐rifampin ☐phenytoin ☐St. John's Wort ☐ A medication that is a strong dual inhibitor of CYP3A4 and P-glycoprotein (P-gp) ☐ ketoconazole (oral) ☐ritonavir	☐Yes *Submit Recipient's complete current medication list* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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