AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Novel Oral Anticoagulants

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is not required for preferred novel oral anticoagulants (NOACs). Prior authorization is required for non-preferred NOACs. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications under the following conditions: 1) Patient does not have a mechanical heart valve; 2) Patient does not have active bleeding; 3) For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA2DS2-VASc score ≥1; 4) A recent creatinine clearance (CrCl) is provided; 5) A recent Child-Pugh score is provided; 6) Patient's current body weight is provided; and 7) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred NOACs. 8) For requests for edoxaban, documentation patient has had five to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred (no PA required if within established quantity limits):	Non-Preferred (PA required):
☐ Eliquis	☐ Savaysa
☐ Pradaxa	
☐ Xarelto	

Strength:	Dosage Instructions:	Quantity:	Days Supply:

Diagnosis:

Does patient have mechanical heart valve?: ☐ Yes ☐ No

Does patient have active bleeding?: ☐ Yes ☐ No

Patient body weight: Date obtained:

Recent creatinine clearance (CrCl): Date obtained:

Recent Child-Pugh score: Date obtained:

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Requests for a diagnosis of atrial fibrillation or stroke prevention:

Risk factor based CHA2DS2-VASc Score	
Risk Factors	**Score**
☐ Congestive heart failure	1
☐ Hypertension	1
☐ Age ≥ 75 years	2
☐ Age between 65 and 74 years	1
☐ Stroke/TIA/TE	2
☐ Vascular disease (previous MI, peripheral arterial disease, or aortic plaque)	1
☐ Diabetes mellitus	1
☐ Female	1
Total	

Document 2 preferred NOAC trials:

Preferred NOAC Trial 1: Name/Dose: Trial dates:

Failure reason:

Preferred NOAC Trial 2: Name/Dose: Trial dates:

Failure reason:

Requests for edoxaban (Savaysa):

Provide documentation of five to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin):

Drug name/dose: Trial dates:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.