

SAVAYSA (exodaban tosylate) 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	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages 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: <input type="checkbox"/> Savaysa tablet		Strength: <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> _____	
Directions:	Quantity:	Refills:	Recipient's weight: _____ lbs/kg
1. What is the Recipient's diagnosis? <i>Check below and document diagnosis code.</i> Acute treatment: <input type="checkbox"/> deep vein thrombosis (DVT) <input type="checkbox"/> pulmonary embolism (PE) Long-term prophylaxis due to: <input type="checkbox"/> atrial fibrillation (non-valvular) Diagnosis codes (required for all diagnoses): _____			<i>Submit medical record documentation supporting the Recipient's diagnosis</i>
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred oral anticoagulants? <i>Check all that apply.</i> <input type="checkbox"/> Eliquis <input type="checkbox"/> Pradaxa <input type="checkbox"/> Xarelto			<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No
3. Does the Recipient have any of the following medical conditions? <i>Check all that apply.</i> <input type="checkbox"/> active pathological bleeding <input type="checkbox"/> moderate to severe mitral valve stenosis <input type="checkbox"/> moderate to severe liver impairment <input type="checkbox"/> mechanical prosthetic heart valve			<input type="checkbox"/> Yes – <i>submit documentation of comorbidities</i> <input type="checkbox"/> No
4. Does the Recipient have results of a recent serum creatinine (SCr) level?			<input type="checkbox"/> Yes – <i>submit documentation of date of test and result</i> <input type="checkbox"/> No
5. Is the Recipient taking any of the following medications that may interact with Savaysa? <i>Check all that apply.</i> <input type="checkbox"/> A medication that may increase the risk of bleeding <input type="checkbox"/> anticoagulant (ex. warfarin, Eliquis, Pradaxa, Xarelto, heparin, enoxaparin, etc.) <input type="checkbox"/> antiplatelet agent (ex. Brilinta, Effient, clopidogrel/Plavix, dipyridamole, etc.) <input type="checkbox"/> aspirin <input type="checkbox"/> NSAID (ex. ibuprofen, naproxen, diclofenac (oral), etc.) <input type="checkbox"/> rifampin <input type="checkbox"/> quinidine <input type="checkbox"/> verapamil			<input type="checkbox"/> Yes <i>Submit Recipient's complete current medication list</i> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
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