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

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 are 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 ☐Renewal request	total # of pgs: _____	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: ☐Savaysa tablet Strength: ☐15 mg ☐30 mg ☐60 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) **Diagnosis codes *(required for all diagnoses)*:** _____	*Submit medical record documentation supporting the Recipient's diagnosis*
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred oral anticoagulants? *Check all that apply.* ☐Eliquis ☐Pradaxa ☐Coumadin/warfarin ☐Xarelto	☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.* ☐No
3. Does the Recipient have any of the following medical conditions? *Check all that apply.* ☐active pathological bleeding ☐moderate to severe mitral valve stenosis ☐moderate to severe liver impairment ☐mechanical prosthetic heart valve	☐Yes – *Submit documentation of comorbidities.* ☐No
4. Does the Recipient have results of a recent serum creatinine (SCr) level?	☐Yes – *Submit documentation of date of test and result.* ☐No
5. Is the Recipient taking any of the following medications that may interact with Savaysa? *Check all that apply.* ☐A medication that may increase the risk of bleeding ☐anticoagulant (ex. warfarin, Eliquis, Pradaxa, Xarelto, heparin, enoxaparin, etc.) ☐antiplatelet agent (ex. Brilinta, Effient, clopidogrel/Plavix, dipyridamole, etc.) ☐aspirin ☐NSAID (ex. ibuprofen, naproxen, diclofenac (oral), etc.) ☐rifampin ☐quinidine ☐verapamil	☐Yes ☐No *Submit Recipient's complete current medication list*

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

Prescriber Signature:	**Date**:

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