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

Prior authorization guidelines for **Anticoagulants** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

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

CLINICAL INFORMATION

Medication requested: Eliquis tablet | Strength: ☐2.5 mg ☐5 mg ☐starter pack ☐other: _____

Directions: | Quantity: | Refills: | Beneficiary's weight: _____ lbs/kg

1. What is the beneficiary's indication for anticoagulation? Check all that apply and provide diagnosis code. *Submit medical record documentation supporting the beneficiary's diagnosis*.

   Acute treatment:
   ☐deep vein thrombosis (DVT) – date of occurrence: _____
   ☐pulmonary embolism (PE) – date of occurrence: _____

   Long-term prophylaxis due to:
   ☐atrial fibrillation (non-valvular)
   ☐history of DVT or PE – date of occurrence: _____

   Post-op DVT prophylaxis:
   ☐hip replacement - surgery date: _____
   ☐knee replacement - surgery date: _____

   Other: ☐_____

   Diagnosis code(s) *(required for all diagnoses)*: _____

2. Does the beneficiary 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. Is the beneficiary 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
   - ☐phenytoin
   - ☐rifampin
   - ☐St. John's Wort

   ☐ A medication that is a strong dual inhibitor of CYP3A4 and P-glycoprotein (P-gp):
   - ☐ketoconazole (oral)
   - ☐itraconazole
   - ☐ritonavir

   ☐Yes ☐No *Submit beneficiary's complete current medication list.*

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

Prescriber Signature: | **Date**:

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