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

PRADAXA (dabigatran) (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 REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request 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: ☐Pradaxa 75 mg capsule ☐Pradaxa 110 mg capsule ☐Pradaxa 150 mg capsule			
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 a DVT or PE **Post-op DVT prophylaxis:** ☐hip replacement – include surgery date: _____ **Diagnosis code *(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 ☐Mitral valve disease ☐Advanced liver disease ☐Prosthetic heart valve (mechanical or biological) ☐history of recurrent bleeds	☐Yes – *submit documentation of comorbidities* ☐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 Pradaxa? *Check all that apply.* ☐A medication that may increase the risk of bleeding ☐anticoagulant (ex. warfarin/Coumadin, Eliquis, Xarelto, Savaysa, heparin, enoxaparin/Lovenox, etc.) ☐antiplatelet agent (ex. Brilinta, Effient, clopidogrel/Plavix, dipyridamole, etc.) ☐aspirin ☐NSAID (ex. ibuprofen, naproxen, diclofenac (oral), etc.) ☐A medication that is a P-glycoprotein (P-gp) inducer ☐carbamazepine ☐rifampin ☐dexamethasone ☐St. John's Wort ☐A medication that is a P-glycoprotein (P-gp) inhibitor ☐dronedarone (Multaq) ☐ketoconazole (oral)	☐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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