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**

# XARELTO (rivaroxaban) (preferred) PRIOR AUTHORIZATION FORM

**Anticoagulants** and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are available 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 ☐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:** ☐Xarelto tablet *(preferred with clinical prior auth required)* ☐Xarelto starter pack *(preferred with clinical prior auth required)* | Strength: | Quantity: | Refills: |
| Directions: | Beneficiary's weight: _____ lbs / kg | | |

1. What is the beneficiary's diagnosis? *Indicate diagnosis 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 ☐coronary artery disease (CAD) ☐peripheral artery disease (PAD)
**Post-op DVT prophylaxis:** ☐hip replacement – include surgery date: _____ ☐knee replacement – include surgery date: _____
**Other:** ☐_____
***Diagnosis code *(required for all diagnoses)*: _____

*Submit medical record documentation supporting the beneficiary's diagnosis.*

2. Does the beneficiary have any of the following medical conditions? *Check all that apply.*
☐active pathological bleeding ☐hepatic impairment associated with coagulopathy
☐moderate or severe hepatic impairment ☐prosthetic heart valve (mechanical or biological)

☐Yes – *Submit documentation of comorbidities.*
☐No

3. Does the beneficiary have results of a recent serum creatinine (SCr) level?

☐Yes – *Submit documentation of date of test and result.*
☐No

4. Does the beneficiary have a feeding tube? ☐If yes, what type (NG, NJ, etc)? _____ *(Submit documentation.)* ☐No

5. Is the beneficiary taking any of the following medications that may interact with Xarelto? *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 combined P-glycoprotein (P-gp) inducer AND strong CYP3A4 inducer
- ☐carbamazepine ☐phenytoin ☐St. John's Wort
- ☐phenobarbital ☐rifampin

☐A medication that is a combined P-glycoprotein (P-gp) inhibitor AND strong CYP3A4 inhibitor
- ☐clarithromycin ☐erythromycin ☐itraconazole ☐ketoconazole
- ☐darunavir ☐fluconazole ☐Kaletra ☐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**: |