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

# PLATELET AGGREGATION INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Platelet Aggregation Inhibitors** 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 REQUEST 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#: |
| **BENEFICIARY INFORMATION** | | Street address: | |
| Beneficiary name: | | Suite #: | City/State/Zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

**Non-preferred medication requested:**

☐aspirin/dipyridamole ER capsule ☐Plavix tablet ☐Yosprala tablet ☐________________

☐Effient tablet ☐ticlopidine tablet ☐Zontivity tablet

| Directions: | Quantity: | Refills: |
|---|---|---|
| Diagnosis *(submit documentation)*: | Dx code (*required*): | |

| **Non-preferred requests** | |
|---|---|
| 1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Platelet Aggregation Inhibitors?<br>☐Aggrenox capsule ☐clopidogrel tablet ☐prasugrel tablet<br>☐Brilinta tablet ☐dipyridamole tablet | ☐Yes – *Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications.*<br>☐No |

| **Zontivity requests** | |
|---|---|
| 1. Does the beneficiary have at least one of the following diagnoses? *Check all that apply.*<br>☐myocardial infarction (MI) ☐peripheral artery disease (PAD) | ☐Yes – *Submit documentation of diagnosis.*<br>☐No – *Submit medical literature supporting the use of Zontivity for the beneficiary's diagnosis.* |
| 2. Will the beneficiary be taking Zontivity with any of the following medications? *Check all that apply.*<br>☐aspirin ☐clopidogrel | ☐Yes<br>☐No<br>*Submit documentation of beneficiary's complete current medication list.* |
| 3. Does the beneficiary have any of the following contraindications to Zontivity? *Check all that apply.*<br>☐history of stroke ☐history of intracranial hemorrhage<br>☐history of transient ischemic attack (TIA) ☐active pathological bleeding | ☐Yes<br>☐No<br>*Submit documentation of beneficiary's pertinent medical history* |
| 4. Will the beneficiary be taking any of the following medications while taking Zontivity? *Check all that apply.*<br>☐anticoagulants ☐SSRIs ☐strong CYP3A4 inducers<br>☐chronic NSAIDs ☐SNRIs ☐strong CYP3A4 inhibitors | ☐Yes<br>☐No<br>*Submit documentation of beneficiary's complete current medication list.* |
| 5. Does the beneficiary have results of recent liver function tests (LFTs)? | ☐Yes<br>☐No<br>*Submit results of beneficiary's most recent LFT results* |

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

| **Prescriber Signature:** | **Date**: |
|---|---|

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