Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Anticoagulant and Antiplatelet Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

Anticoagulants

- ☐ Savaysa (edoxaban)
- ☐ Xarelto (rivaroxaban 2.5 mg)

Antiplatelet

- ☐ Zontivity (vorapaxar)

Dose and frequency of medication requested _____ **Duration of medication requested** _____

Indication for Anticoagulant

- ☐ Nonvalvular atrial fibrillation
- ☐ Reduce the risk of major cardiovascular (CV) events in coronary artery disease (CAD)/peripheral artery disease (PAD)
- ☐ Reduce the risk of recurrence of DVT and PE
- ☐ Treatment of DVT
- ☐ Treatment of PE
- ☐ Other _____

Indication for Antiplatelet

- ☐ Non-ST elevation myocardial infarction (MI)
- ☐ PAD
- ☐ ST elevation MI
- ☐ Other _____

Section I. Please complete for Savaysa requests.

1. Has the member had a trial with Eliquis?
   - ☐ Yes. Please list the dates/duration of trials and outcomes below.
     Dates/duration of use _____
     Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
     Briefly describe details of adverse reaction, inadequate response, or other.
     _____
   - ☐ No. Please describe why Eliquis is not appropriate for this member.
     _____
2. Has the member had a trial with Pradaxa?
   - ☐ Yes. Please list the dates/duration of trials and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please describe why Pradaxa is not appropriate for this member.

3. Has the member had a trial with Xarelto?

☐ Yes. Please list the dates/duration of trials and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please describe why Xarelto is not appropriate for this member.

_____

Section II. Please complete for Xarelto 2.5 mg requests.

Is the member receiving concurrent aspirin therapy?

☐ Yes. Dose _____ Frequency _____ ☐ No

Section III. Please complete for Zontivity requests.

1. Does the member have a history of stroke, transient ischemic attack, or intracranial hemorrhage? ☐
   Yes ☐ No
2. Is the member receiving concurrent aspirin and/or clopidogrel therapy?
   ☐ Yes. Drug _____ Dose _____ Frequency _____ ☐ No

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

over

Prescribing provider’s attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider’s signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____