

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Pradaxa[®] (dabigatran etexilate) pellets & 110 mg capsules only

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____ Date: _____

Renal Dosing Adjustments: Creatinine Clearance will be calculated for patients >70 years old.

Age: _____ Height: _____ Weight: _____ Scr: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Member must meet **BOTH** of the following **AND** FDA approved age, indication & dose must be attested to below

- Member is **NOT** using warfarin concomitantly
- Member meets **ONE** of the following:
 - For members > 18 years of age: Member has tried and failed Xarelto[®] **AND** Eliquis[®]
 - For members ≤ 17 years of age: Member has tried and failed Xarelto[®]

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For Adults requesting 110 mg CAPSULE formulation: Confirm indication & corresponding dosage below	
<input type="checkbox"/> Prophylaxis DVT/PE	<input type="checkbox"/> Hip Replacement: 110 mg 1 st day- then 220 mg daily – minimum of 10 to 14 days: duration can be up to 35 days
For Pediatrics requesting 110 mg CAPSULE formulation: Select indication, weight range & corresponding dosage below	
<input type="checkbox"/> Treatment and Reduction in the Risk of Recurrence of VTE in pediatric patients 8 to < 18 years of age	
<input type="checkbox"/> 11 kg to ≤ 15 kg: 75 mg BID <input type="checkbox"/> 16 kg to ≤ 25 kg: 110 mg BID <input type="checkbox"/> 26 kg to ≤ 40 kg: 150 mg BID <input type="checkbox"/> 41 kg to ≤ 60 kg: 185 mg BID <input type="checkbox"/> 61 kg to ≤ 80 kg: 220 mg BID <input type="checkbox"/> 81 kg or greater: 260 mg BID	
For Pediatrics requesting ORAL PELLETT formulation: Select indication, weight range & corresponding dosage below <u>AND</u> for member's older than 8 years of age - please provide clinical-based reasoning and attach applicable documentation why the member cannot swallow capsules:	
<hr/> <hr/> <hr/> <hr/>	
<input type="checkbox"/> Treatment and Reduction in the Risk of Recurrence of VTE in pediatric patients 2 years to < 12 years of age	
<input type="checkbox"/> ≥7 kg to < 9 kg: 70 mg BID <input type="checkbox"/> ≥ 9 kg to < 11 kg: 90 mg BID <input type="checkbox"/> ≥ 11 kg to < 13 kg: 110 mg BID <input type="checkbox"/> ≥ 13 kg to < 16 kg: 140 mg BID <input type="checkbox"/> ≥ 16 kg to < 21 kg: 170 mg BID <input type="checkbox"/> ≥ 21 to < 41 kg: 220 mg BID <input type="checkbox"/> ≥ 41 kg or greater: 260 mg BID	

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For Pediatrics requesting ORAL PELLETT formulation: Select indication, weight range & corresponding dosage below			
<input type="checkbox"/> Treatment and Reduction in the Risk of Recurrence of VTE in pediatric patients < 2 years of age			
<input type="checkbox"/> 3 kg to less than 4 kg	<input type="checkbox"/> 3 to less than 6 months	30 mg	one 30 mg packet BID
<input type="checkbox"/> 4 kg to less than 5 kg	<input type="checkbox"/> 3 to less than 10 months	40 mg	one 40 mg packet BID
<input type="checkbox"/> 5 kg to less than 7 kg	<input type="checkbox"/> 3 to less than 5 months	40 mg	one 40 mg packet BID
	<input type="checkbox"/> 5 to less than 24 months	50 mg	one 50 mg packet BID
<input type="checkbox"/> 7 kg to less than 9 kg	<input type="checkbox"/> 3 to less than 4 months	50 mg	one 50 mg packet BID
	<input type="checkbox"/> 4 to less than 9 months	60 mg	two 30 mg packets BID
	<input type="checkbox"/> 9 to less than 24 months	70 mg	one 30 mg packet plus one 40 mg packet BID
<input type="checkbox"/> 9 kg to less than 11 kg	<input type="checkbox"/> 5 to less than 6 months	60 mg	two 30 mg packets BID
	<input type="checkbox"/> 6 to less than 11 months	80 mg	two 40 mg packets BID
	<input type="checkbox"/> 11 to less than 24 months	90 mg	one 40 mg packet plus one 50 mg packet BID
<input type="checkbox"/> 11 kg to less than 13 kg	<input type="checkbox"/> 8 to less than 18 months	100 mg	two 50 mg packets BID
	<input type="checkbox"/> 18 to less than 24 months	110 mg	one 110 mg packet BID
<input type="checkbox"/> 13 kg to less than 16 kg	<input type="checkbox"/> 10 to less than 11 months	100 mg	two 50 mg packets BID
	<input type="checkbox"/> 11 to less than 24 months	140 mg	one 30 mg packet plus one 110 mg packet BID
<input type="checkbox"/> 16 kg to less than 21 kg	<input type="checkbox"/> 12 to less than 24 months	140 mg	one 30 mg packet plus one 110 mg packet BID
<input type="checkbox"/> 21 kg to less than 26 kg	<input type="checkbox"/> 18 to less than 24 months	180 mg	one 30 mg packet plus one 150 mg packet BID

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****