OPTIMA HEALTH PLAN

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 1-800-750-9692**. 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 may be delayed.**

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

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

Member Name: _____

Member Optima #: _____ **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	
❑ Prophylaxis DVT/PE	❑ Hip Replacement: **110 mg** 1st 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

❑ Treatment and Reduction in the Risk of Recurrence of VTE in pediatric patients 8 to < 18 years of age

- ❑ 11 kg to ≤ 15 kg: 75 mg BID
- ❑ 16 kg to ≤ 25 kg: 110 mg BID
- ❑ 26 kg to ≤ 40 kg: 150 mg BID
- ❑ 41 kg to ≤ 60 kg: 185 mg BID
- ❑ 61 kg to ≤ 80 kg: 220 mg BID
- ❑ 81 kg or greater: 260 mg BID

For Pediatrics requesting ORAL PELLET 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:

_____

_____

_____

_____

❑ Treatment and Reduction in the Risk of Recurrence of VTE in pediatric patients 2 years to < 12 years of age

- ❑ ≥7 kg to < 9 kg: 70 mg BID
- ❑ ≥ 9 kg to < 11 kg: 90 mg BID
- ❑ ≥ 11 kg to < 13 kg: 110 mg BID
- ❑ ≥ 13 kg to < 16 kg: 140 mg BID
- ❑ ≥ 16 kg to < 21 kg: 170 mg BID
- ❑ ≥ 21 to < 41 kg: 220 mg BID
- ❑ ≥ 41 kg or greater: 260 mg BID

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

***Approved by Pharmacy and Therapeutics Committee**: 10/21/2010
UPDATED/REVISED: ~~4/1/2011; 6/14/2011; 8/18/2011; 3/20/2012; 5/8//2014; 9/23/2014; 11/2/2014; 5/22/2015; 12/28/2015; 1/26/2016; 12/19/2016; 8/16/2017;11/24/2017; (Reformatted) 6/19/2019; 3/31/2023;~~ **10/17/2023**