Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Pradaxa (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Pradaxa (FA-PA).

Drug Name (select from list of drugs shown)
Pradaxa (dabigatran etexilate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? Y N

   Available Formulary Alternatives: Eliquis, Xarelto, or Warfarin

   [If yes, then provide your patient with a new prescription for the preferred product.]

2. Has the patient tried and had an intolerance to TWO of the following: Eliquis, Xarelto, or warfarin? Drug Name, Reason for Failure. Y N _____

   [If yes, then documentation is required for approval.]

	[If yes, then skip to question 4.]	
3.	Has the patient tried and had an inadequate treatment response (i.e., failure to adequately resolve thrombus) to ONE of the following: Eliquis or Xarelto? Drug Name, Reason for Failure.	Y N
	[If yes, then documentation is required for approval.]	
4.	Is the requested drug being prescribed for any of the following reasons: A) to reduce the risk of stroke and systemic embolism in a patient with non-valvular atrial fibrillation, B) the treatment of deep venous thrombosis (DVT) or pulmonary embolism (PE) in a patient who has been treated with a parenteral anticoagulant for 5-10 days, C) to reduce the risk of recurrence of deep venous thrombosis or pulmonary embolism in a patient who has been previously treated?	Y N
	[If yes, then no further questions.]	
5.	Is the requested drug being prescribed for the prophylaxis of deep venous thrombosis (DVT) or pulmonary embolism (PE) following hip replacement surgery?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date