**Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants**

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| Criteria 1 | NP Criteria- Savaysa, Dabigatran Cap [Pradaxa (P, BvG)] |
| Criteria 2 | Preferred with ARs |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SAVAYSA | 073293 | GCNSeqNo |
| SAVAYSA | 073294 | GCNSeqNo |
| SAVAYSA | 073295 | GCNSeqNo |
|  | DABIGATRAN | 063997 | GCNSeqNo |
|  | DABIGATRAN | 066781 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1004 |  | Select | Is the request for Dabigatran? | Y | 1005 |
| N | END (Pending Manual Review) |
| 8 | 1005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants | | |
| **Criteria Subtitle** | Pradaxa Pellet Pak, Xarelto Susp | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| Pradaxa Pellet Pak | 082440 | GCNSeqNo |
| Pradaxa Pellet Pak | 082441 | GCNSeqNo |
| Pradaxa Pellet Pak | 082442 | GCNSeqNo |
| Pradaxa Pellet Pak | 082443 | GCNSeqNo |
| Pradaxa Pellet Pak | 082444 | GCNSeqNo |
|  | Pradaxa Pellet Pak | 082445 | GCNSeqNo |
|  | Xarelto Susp | 082570 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1233 |  | Select | Is the patient older than 12 years?  Please note: a PA is only required for patients older than 12 years. | Y | 1234 |
| N | 1236 |
| 2 | 1234 |  | Select and Free Text | Is the patient able to swallow a standard tablet and/or capsule formulation?  If no, please submit documentation. | Y | 1235 |
| N | END (Pending Manual Review) |
| 3 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 4 | 1236 |  | Free Text | A PA is not required for those 12 years of age and younger. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/11/2023 |
| **Other** |  |