Please note: All information below is required to process this request
For urgent requests please call 1-800-711-4555
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Eliquis® Prior Authorization Request Form

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
Is This Medication a New Start? ❑ Yes ❑ No	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
❑ Atrial fibrillation (AF)
❑ Prophylaxis of venous thromboembolism (VTE) after orthopedic surgery
❑ Reduction in the risk of recurrence of deep vein thrombosis (DVT) or pulmonary embolism (PE)
❑ Treatment of DVT or PE
❑ Other diagnosis: _____ ICD-9/10 Code(s): _____

Continuation of therapy:
❑ Yes ❑ No Is the requested medication being used as continuation of therapy upon hospital discharge?
Atrial fibrillation:
❑ Yes ❑ No Does the patient have a bioprosthetic heart valve?
❑ Yes ❑ No Does the patient have a mechanical prosthetic heart valve?
Prophylaxis of VTE after orthopedic surgery:
❑ Yes ❑ No Does the patient have a completion of total knee or total hip replacement surgery?
Reduction in the risk of recurrence of DVT or PE:
❑ Yes ❑ No Does the patient have a previous diagnosis of DVT or PE?
❑ Yes ❑ No Has the patient been treated with an anticoagulant [e.g. warfarin, Pradaxa (dabigatran), Eliquis (apixaban), Xarelto (rivaroxaban)] for at least 3 months prior to this request?

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information from OptumRx that is privileged, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0101, Irvine, CA 92614.** www.optumrx.com