05/02/2014

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Xarelto (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xarelto (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Xarelto (rivaroxaban)

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:** _____

Please circle the appropriate answer for each question.

1. Is the patient an adult over 18 years of age? Y N
2. Is Xarelto being prescribed for deep vein thrombosis (DVT) prophylaxis for a patient undergoing knee replacement surgery? Please provide surgery date Y N

   [If yes, then no further questions.]

3. Is Xarelto being prescribed for deep vein thrombosis (DVT) prophylaxis for a patient undergoing hip replacement surgery? Please provide surgery date Y N

   [If yes, then no further questions.]

4. Is Xarelto being prescribed for one of the following Y N

   Treatment of DVT, PE \ For the reduction in the risk of recurrent DVT and/or PE \ Non-valvular atrial fibrillation

5. Has patient had a documented failure/intolerance to warfarin (e.g., inability to achieve therapeutic INR on warfarin) OR is the patient unable to go in for INR monitoring (patient is in a rural area)? Please list reason for treatment failure Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**