UnitedHealthcare Community Plan

Xarelto
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Is Xarelto being requested for one of the following:** *(Check all that apply)* □ Continuation of therapy upon hospital discharge. List start date / admission & discharge date: _____ □ Atrial Fibrillation (AF) □ Chronic coronary artery disease (CAD) □ Patient has or is scheduled to have total hip replacement surgery, List surgery date: _____ □ Patient has or is scheduled to have total knee replacement surgery, List surgery date: _____ □ Peripheral artery disease (PAD) □ Previous diagnosis of deep vein thrombosis (DVT) or pulmonary embolism (PE) □ Treatment of Deep Vein Thrombosis (DVT) □ Treatment of Pulmonary Embolism (PE)
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following:** *(If yes, check all that apply and complete Section D above)* □ Eliquis □ Savaysa
ATRIAL FIBRILLATION (AF)	
□ **Yes** □ **No**	**Does the patient have an artificial heart valve?**
PREVIOUS DIAGNOSIS OF DVT OR PE	
□ **Yes** □ **No**	**Has the patient been treated with an anticoagulant [e.g., warfarin, Eliquis (apixaban)] for at least 6 months prior to request?** *(If yes, complete Section D above)*
CHRONIC CORONARY ARTERY DISEASE OR PERIPHERAL ARTERY DISEASE	
□ **Yes** □ **No**	**Is the patient on concurrent aspirin therapy?**

Provider Signature: _____ Date: _____