

## PLATELET AGGREGATION INHIBITORS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Platelet Aggregation Inhibitors, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Platelet Aggregation Inhibitors** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA# _____)			
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

<b>Non-preferred medication requested</b> <input type="checkbox"/> aspirin/dipyridamole ER capsule <input type="checkbox"/> Plavix tablet <input type="checkbox"/> Zontivity tablet		
<input type="checkbox"/> Persantine tablet <input type="checkbox"/> ticlopidine tablet		
Directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):	Dx code ( <i>required</i> ):	
<b>Complete section applicable to the requested medication.</b>		
<b>Section A: Brand name Plavix and Persantine requests</b>		
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred FDA-approved therapeutically equivalent generic product?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications</i> <input type="checkbox"/> No
<b>Section B: Ticlopidine requests</b>		
1. Is ticlopidine prescribed for one of the following indications? <i>Check all that apply.</i> <input type="checkbox"/> prevention of stroke <input type="checkbox"/> prevention of stent thrombosis		<input type="checkbox"/> Yes – <i>submit documentation of indication</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of ticlopidine for the Recipient's indication</i>
2. <i>If ticlopidine is prescribed for stroke prevention</i> , does the Recipient have a history of trial and failure, contraindication, or intolerance to the following? <i>Check all that apply.</i> <input type="checkbox"/> Aggrenox ( <i>aspirin/dipyridamole</i> ) <input type="checkbox"/> clopidogrel ( <i>Plavix</i> )		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications</i> <input type="checkbox"/> No
3. <i>For stent thrombosis prevention</i> , does the Recipient have a history of trial and failure, contraindication, or intolerance to clopidogrel ( <i>Plavix</i> )?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of trial and failure, intolerance, and contraindications</i> <input type="checkbox"/> No
<b>Section C: Zontivity requests</b>		
1. Does the Recipient have at least one of the following diagnoses? <i>Check all that apply.</i> <input type="checkbox"/> myocardial infarction (MI) <input type="checkbox"/> peripheral artery disease (PAD)		<input type="checkbox"/> Yes – <i>submit documentation of diagnosis</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of Zontivity for the Recipient's diagnosis</i>
2. Will the Recipient be taking Zontivity with any of the following medications? <i>Check all that apply.</i> <input type="checkbox"/> aspirin <input type="checkbox"/> clopidogrel		<input type="checkbox"/> Yes <i>Submit documentation of Recipient's complete current medication list.</i> <input type="checkbox"/> No
3. Does the Recipient have any of the following contraindications to Zontivity? <i>Check all that apply.</i> <input type="checkbox"/> history of stroke <input type="checkbox"/> history of intracranial hemorrhage <input type="checkbox"/> history of transient ischemic attack (TIA) <input type="checkbox"/> active pathological bleeding		<input type="checkbox"/> Yes <i>Submit documentation of Recipient's pertinent medical history</i> <input type="checkbox"/> No
4. Will the Recipient be taking any of the following medications while taking Zontivity? <i>Check all that apply.</i> <input type="checkbox"/> anticoagulants <input type="checkbox"/> SSRIs <input type="checkbox"/> strong CYP3A4 inducers <input type="checkbox"/> chronic NSAIDs <input type="checkbox"/> SNRIs <input type="checkbox"/> strong CYP3A4 inhibitors		<input type="checkbox"/> Yes <i>Submit documentation of Recipient's complete current medication list.</i> <input type="checkbox"/> No
5. Does the Recipient have results of recent liver function tests (LFTs)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit results of Recipient's most recent LFT results</i>

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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