AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Vorapaxar (Zontivity™)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for vorapaxar (Zontivity™). Payment will be considered under the following conditions: 1) Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2) Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3) Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4) Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

☐ Zontivity™

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Does patient have history of:

Stroke? ☐ Yes ☐ No TIA: ☐ Yes ☐ No

Intracranial bleeding: ☐ Yes ☐ No Does patient have active peptic ulcer? ☐ Yes ☐ No

Treatment failure with aspirin plus clopidogrel:

Aspirin trial dose: Trial dates:

Clopidogrel trial dose: Trial dates:

Reason for failure:

Vorapaxar will be taken concurrently with:

Aspirin: ☐ Yes ☐ No Clopidogrel: ☐ Yes ☐ No

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.