

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

PRADAXA (dabigatran)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992 note the new fax number**

CRITERIA:

- Documentation of one of the following diagnoses:
 - Atrial Fibrillation OR
 - Another condition requiring anticoagulation.
- Documented failure to maintain a therapeutic INR or warfarin or intolerance to warfarin.

AUTHORIZATION:

Authorization period is one year, or anticipated duration of treatment if shorter than one year

RE-AUTHORIZATION:

Updated letter of medical necessity

2/16/11

<http://health.utah.gov/medicaid/pharmacy>