Health PEI

# SPECIAL AUTHORIZATION REQUEST

## Dabigatran(Pradaxa®), Rivaroxaban(Xarelto®), Apixaban(Eliquis®)

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

### SECTION 1 – PRESCRIBER INFORMATION

| NAME AND MAILING ADDRESS |
|---|
| PHONE NUMBER (INCLUDE AREA CODE): |
| FAX NUMBER (INCLUDE AREA CODE): |

### SECTION 2 – PATIENT INFORMATION

| PATIENT (FAMILY NAME) | |
|---|---|
| PATIENT (GIVEN NAME) | |
| DATE OF BIRTH (YYYY/MM/DD) | DATE OF APPLICATION (YYYY/MM/DD) |
| PERSONAL HEALTH NUMBER (PHN) | |

### SECTION 3 – BACKGROUND DIAGNOSTIC INFORMATION

**DIAGNOSIS:**

**1.** ☐ Treatment/prevention of recurrent deep vein thrombosis (DVT) or pulmonary embolus (PE). Approval period up to 6 months.

☐ **Rivaroxaban –** recommended dose of 15mg twice daily for three weeks followed by 20mg once daily

☐ **Apixaban –** recommended dose of 10mg twice daily for seven days followed by 5mg twice daily

Note: There is limited data regarding the use of novel oral anticoagulants in patients with malignancy and VTE.

**2.** ☐ Non-valvular atrial fibrillation CHADS$_2$ score: _____

Creatinine Clearance (CrCl): _____ml/min Date: _____

**DOSING IN Atrial Fibrillation**:

☐ **Apixaban (CrCl of at least 25 ml/min)**
- ☐ **5mg twice daily**
- ☐ **2.5mg twice daily (recommended if patient has at least two of: Age ≥80, weight ≤60kg, or serum creatinine ≥133 mmol/L)**

☐ **Dabigatran**
- ☐ **150mg twice daily, patient has CrCl or eGFR of at least 50ml/min**
- ☐ **110 mg twice daily, patient has CrCl or eGFR of at least 30-49 ml/min**

☐ **Rivaroxaban**
- ☐ **20mg once daily, patient has CrCl or eGFR of at least 50ml/min**
- ☐ **15mg once daily, patient has CrCl or eGFR of at least 30-49 ml/min**

☐ After **at least** a 2 month warfarin trial INR testing results are outside the desired range for at least 35% of the tests (please provide INR log while on warfarin therapy), **OR**

☐ Anticoagulation with warfarin in contraindicated or not possible due to:

Other reasons as applicable (please provide info) _____

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI High-Cost Drugs Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

**PRESCRIBER SIGNATURE (REQUIRED)** **DATE**

**FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.**

**APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES**