

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Arixtra® (fondaparinux)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Form with checkboxes for Arixtra (fondaparinux) and fields for strength, directions, and quantity per 30 days.

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Indicate diagnosis:

- Acute Deep Vein Thrombosis (DVT) treatment in conjunction with warfarin
DVT prevention in abdominal surgery associated with venous thromboembolism (VTE)
DVT prevention in due to knee replacement surgery
DVT prevention w/ hip fracture or total hip replacement surgery
Other:
Long term DVT treatment in cancer patients
Long term DVT treatment when warfarin is contraindicated or not tolerated
Long term treatment of Pulmonary Embolism (PE)
Yes No Was Arixtra administered in the hospital for PE?
If yes: What was hospital discharge date?

8. PHYSICIAN SIGNATURE

Form with fields for Prescriber or Authorized Signature and Date, and a disclaimer: Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician.

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