

## I. Requirements for Prior Authorization of Platelet Aggregation Inhibitors

### A. Prescriptions That Require Prior Authorization

Prescriptions for Platelet Aggregations Inhibitors which meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Platelet Aggregation Inhibitor. See Preferred Drug List (PDL) for the list of preferred Platelet Aggregation Inhibitors at: <https://papdl.com/preferred-drug-list>.

### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Platelet Aggregation Inhibitor, the determination of whether the requested prescription is medically necessary will be subject to physician review and will take into account the following:

1. For a non-preferred Platelet Aggregation Inhibitor, whether the recipient:
  - a. Has a documented history of therapeutic failure, intolerance, or contraindication to the preferred Platelet Aggregation Inhibitors.

**OR**

2. For Zontivity (vorapaxar), whether the recipient:
  - a. Is being treated for a condition that is U.S. Food and Drug Administration (FDA) approved or a medically accepted indication; **AND**
  - b. Will be taking Zontivity in addition to aspirin and/or clopidogrel; **AND**
  - c. Is being prescribed Zontivity by, or in consultation with, a cardiologist or other vascular specialist; **AND**
  - d. Does not have any contraindications to Zontivity; **AND**
  - e. Will not be concomitantly taking any of the following:
    - i. Anticoagulants
    - ii. Chronic NSAIDs
    - iii. SSRIs
    - iv. SNRIs

**AND**

- f. Had any potential drug interactions addressed by the prescriber; **AND**
- g. Does not have severe hepatic impairment

**OR**

3. The recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Clinical Review Process

Prior authorization personnel will refer the request to a physician reviewer to assess the medical necessity of the Platelet Aggregation Inhibitor. If the guidelines in Section B are met, the physician reviewer will prior authorize the prescription. If the guidelines are not met, the physician reviewer will approve the request when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

**ZONTIVITY (vorapaxar) PRIOR AUTHORIZATION FORM**

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/State/Zip:
Beneficiary ID#:		DOB:	Phone:	Fax:
Medication will be billed via: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medical (Jcode: _____)			Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's Office <input type="checkbox"/> Home <input type="checkbox"/> Other	

**CLINICAL INFORMATION**

<b>Medication requested:</b>	Zontivity tablet	Strength:	
Directions:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):	
Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Platelet Aggregation Inhibitors? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.		<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	
Does the beneficiary 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 beneficiary's diagnosis.</i>	
Will the beneficiary 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 beneficiary's complete current medication list.</i> <input type="checkbox"/> No	
Does the beneficiary 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 beneficiary's pertinent medical history</i> <input type="checkbox"/> No	
Will the beneficiary 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 beneficiary's complete current medication list.</i> <input type="checkbox"/> No	
Does the beneficiary have results of recent liver function tests (LFTs)?		<input type="checkbox"/> Yes <i>Submit results of beneficiary's most recent LFT results</i> <input type="checkbox"/> No	

**PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION**

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