Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

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.

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ZONTIVITY (vorapaxar) PRIOR AUTHORIZATION FORM

☐New request ☐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: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Medication requested: Zontivity tablet		Strength:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):

Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Platelet Aggregation Inhibitors? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications.* ☐No
Does the beneficiary have at least one of the following diagnoses? *Check all that apply.* ☐myocardial infarction (MI) ☐peripheral artery disease (PAD)	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of Zontivity for the beneficiary's diagnosis.*
Will the beneficiary be taking Zontivity with any of the following medications? *Check all that apply.* ☐aspirin ☐clopidogrel	☐Yes ☐No *Submit documentation of beneficiary's complete current medication list.*
Does the beneficiary have any of the following contraindications to Zontivity? *Check all that apply.* ☐history of stroke ☐history of intracranial hemorrhage ☐history of transient ischemic attack (TIA) ☐active pathological bleeding	☐Yes ☐No *Submit documentation of beneficiary's pertinent medical history*
Will the beneficiary be taking any of the following medications while taking Zontivity? *Check all that apply.* ☐anticoagulants ☐SSRIs ☐strong CYP3A4 inducers ☐chronic NSAIDs ☐SNRIs ☐strong CYP3A4 inhibitors	☐Yes ☐No *Submit documentation of beneficiary's complete current medication list.*
Does the beneficiary have results of recent liver function tests (LFTs)?	☐Yes ☐No *Submit results of beneficiary's most recent LFT results*

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date: