Health PEI

SPECIAL AUTHORIZATION REQUEST

Apixaban (Eliquis®) Dabigatran (Pradaxa®) Edoxaban (Lixiana®) Rivaroxaban (Xarelto®)

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

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

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

☐ **Edoxaban –** recommended dose of 60mg once daily following parenteral anticoagulation for 5-10 days (30mg daily recommended if moderate renal impairment, body wt ≤ 60kg, or concomitant use of some P-gp inhibitors)

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

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)**	☐ **Edoxaban**	☐ **Dabigatran**	☐ **Rivaroxaban**
☐ **5mg twice daily**	☐ **60mg once daily**	☐ **150mg twice daily**	☐ **20mg once daily**
☐ **2.5mg twice daily (if patient has at least two of: Age ≥80, wt ≤60kg, or serum creatinine ≥133 mmol/L)**	☐ **30mg once daily if either wt ≤ 60kg, CrCl 30-50 ml/min or concomitant use of some P-gp inhibitors**	☐ **110 mg twice daily if appropriate**	☐ **15mg once daily, patient CrCl 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 is 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

JULY 2019/BLC