P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Xarelto®
(rivaroxaban)

Therapeutic use: reduce the risk of stroke and embolism in patients with non-valvular atrial fibrillation
Quantity Limit:

- Atrial fibrillation: 15 - 20 mg once daily

Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with non-valvular atrial fibrillation?	❑ Yes	❑ No
2.	Has warfarin therapy been considered? If no, please explain: _____ _____	❑ Yes	❑ No
3.	What is the patient's $CHADS_2$ score? _____		
Xarelto 10mg once daily for up to 35 days for the prophylaxis of postoperative deep vein thromobosis following knee or hip replacement surgery does not require prior authorization.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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