

Pradaxa (dabigatran etexilate)

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet	Date: ____ / ____ / ____
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____
Prescriber's Specialty: _____	Prescriber's Fax Number: _____
Prescriber's Office Address: _____	
Street	Suite # City State Zip
Patient Name: _____	
Patient ID: _____	Patient DOB: ____ / ____ / ____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Is the patient able to obtain a goal INR with warfarin therapy? Yes No

3. Is warfarin therapy contraindicated in this patient? Yes No

If "Yes", please describe: _____

Printed Name

Signature

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