

Xarelto® (rivaroxaban)

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: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

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.

- For which diagnosis is this medication being prescribed?
 Prevention of deep vein thrombosis (DVT) in members undergoing knee or hip replacement surgery
 Reduction of stroke and systemic embolism risk in members with nonvalvular atrial fibrillation (AF)
- Has the member received Xarelto therapy within the past 120 days?
 Yes No
- Does the member have a documented failure with or contraindication to warfarin therapy?
 Yes No

Printed Name _____ Signature _____

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