reformulary® GROUP

Special Authorization Request Form, for:

rivaroxaban 2.5 mg **(generic)**

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: ___________________________________ Last name: ____________________________________

Group number: ________________________________ Certificate number: ____________________________

Date of birth (DD/MM/YY):______________________ Gender:____

Address: ____

City/Town:____________________________________ Province:_______ Postal code: __________________

Email:____ Phone:____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? ❑ Yes ❑ No

If yes, provide the following: Name of plan member: ____

Policy/Plan number: ___________________________ Certificate number: ____________________________

Patient assistance program

Have you enrolled in a patient assistance program? ❑ Yes ❑ No

If yes, provide your patient assistance program ID number: ____

Provide the patient assistance program:

Contact name:_________________________________ Phone:____

© 2024 Reformulary Group

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: ______________________________ Last name: ______________________________

License: ______________________________ Phone: ______________________________

Address: ____

City/Town: ______________________________ Province: _____ Postal code: ________________

Physician's signature: ____

(confirming the below information to be correct)

Drug being requested through Special Authorization

❑ New request ❑ Request for continuation of therapy

DIN: ______________________________ Product name: ______________________________

Strength: 2.5 mg tablet ONLY ________________ Dosage: ______________________________

Site of Administration

❑ Home ❑ Private clinic ❑ Hospital

❑ Doctor's office ❑ Cancer centre ❑ LTC facility

CLINICAL INFORMATION

Diagnosis

- ❑ Concomitant coronary artery disease and peripheral artery disease (refer to definition under Special Notes)

Physician specialty

- ❑ Cardiologist
- ❑ Other specialist, please specify ____

CLINICAL INFORMATION (cont.)

Criteria for initial coverage for Concomitant coronary artery disease and/or peripheral artery disease, confirm the following:

- ❑ Patient is 18 years of age or older; and
- ❑ Patient has a diagnosis of coronary artery disease and/or peripheral artery disease (see below); and
- ❑ Patient is:
  - ❑ 65 years or older; OR
  - ❑ younger than 65 years AND has at least two additional risk factors (current smoker, diabetes mellitus, estimated glomerular filtration rate < 60 mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago)

NOTE: Duration of initial approval is indefinite

SPECIAL NOTES

Exclusion criteria:

Patient should not have any of the following characteristics:

- at high risk of bleeding
- a history of stroke within one month of treatment initiation or any history of hemorrhagic or lacunar stroke
- severe heart failure with a known ejection fraction less than 30% or New York Heart Association class III or IV symptoms
- an estimated glomerular filtration rate less than 15 mL/min
- require dual antiplatelet therapy, other non-ASA antiplatelet therapy, or oral anticoagulant therapy

Coronary artery disease (CAD): Patients are defined as having one or more of the following:

- myocardial infarction within the last 20 years
- multi-vessel coronary disease (i.e., stenosis of ≥ 50% in two or more coronary arteries, or in one coronary territory if at least one other territory has been revasclarlized) with symptoms or history of stable or unstable angina
- multi-vessel percutaneous coronary intervention
- multi-vessel coronary artery bypass graft surgery

Peripheral artery disease (PAD): Patients are defined as having one or more of the following:

- previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries
- previous limb or foot amputation for arterial vascular disease
- history of intermittent claudication and one or more of the following: 1) an anklebrachial index less than 0.90, or 2) significant peripheral artery stenosis (≥ 50%) documented by angiography or by duplex ultrasound
- previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography

© 2024 Reformulary Group

Describe any intolerances to therapy: ____

____

____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? ___________________________________

____

____

Update: October 2024