

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**ARIXTRA** (fondaparinux sodium)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Ext. and opt. \_\_\_\_\_ Fax# \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**TELEPHONE AUTHORIZATION OR WRITTEN REQUEST  
FAX WRITTEN REQUESTS TO (801) 536-0477**

**CRITERIA:**

- ▶ Pre-operative for 3 days to stop coumadin prior to surgery
- ▶ Post-operative for 5 days to achieve therapeutic INR on Coumadin
- ▶ Post-operative prevention of DVT in patients with abdominal surgeries and below i.e. hip, knee, and ankle not including foot and toes. Maximum of 10 days
- ▶ Treatment of acute DVT when administered in conjunction with coumadin

**OR**

- ▶ Treatment of PE when administered in conjunction with coumadin when initial therapy is administered in the hospital.

**RE-AUTHORIZATION:**

Based on INR. Considered on an individual basis.

