Market Applicability/Effective Date														
Market	**FL & FHK**	**FL MMA**	**FL LTC**	**GA**	**KS**	**KY**	**LA**	**MD**	**NJ**	**NV**	**NY**	**TN**	**TX**	**WA**
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

Medication	Comments
Argatroban	N/A

OVERRIDE(S)

Prior Authorization of Benefits

APPROVAL DURATION

6 Months

APPROVAL CRITERIA

Requests for Argatroban may be approved if the following criteria are met:

I. Thrombosis - Treatment

A. Treatment of thrombosis in individuals with heparin-induced thrombocytopenia;

-**OR-**

B. Treatment of cerebral thrombosis.

II. Thrombosis - Prevention

A. Prophylaxis of thrombosis in individuals with heparin-induced thrombocytopenia;

-OR-

B. Prophylaxis of cerebral thrombosis.

III. The use of argatroban (Argatroban) may **NOT** be approved for the following:

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

Market Applicability/Effective Date														
Market	**FL & FHK**	**FL MMA**	**FL LTC**	**GA**	**KS**	**KY**	**LA**	**MD**	**NJ**	**NV**	**NY**	**TN**	**TX**	**WA**
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

- Individuals in whom long term warfarin treatment is generally indicated and appropriate and where either LMWH has not been shown to improve health outcomes compared to warfarin, or who do not exhibit intolerance or have contraindications to warfarin and have not developed recurrent VTE while on therapeutic doses of warfarin.
- To prevent thrombosis related to long term indwelling central venous lines in individuals with cancer.

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.