PRIOR AUTHORIZATION COVER SHEET

NOTE: This document is intended to support prior authorization submission requests for WATCHMAN™. Payer policies will vary, and patient eligibility should be verified prior to treatment. Please reference individual payer policy requirements prior to submitting prior authorizations.

PROCEDURE DATE

____/____/____

NAME ____________

☐ MALE

☐ FEMALE

DOB ____/____/____

MD ____________

INSURANCE ____________

THE FOLLOWING PRIOR AUTHORIZATION SUBMISSION INCLUDES

Patient history & physical (H&P), office notes and/or encounter notes	YES ☐
Documented risk of stroke based on qualifying $CHADS_2$ or $CHAD_2DS_2$-VASc score	YES ☐
Documented bleeding risk using validated scores, e.g., HAS-BLED	YES ☐
Documentation of the patient's rationale for seeking an alternative to long-term anticoagulation therapy	YES ☐
Documentation of past coagulation related complications	YES ☐
Documentation that the patient can tolerate short-term anticoagulation therapy	YES ☐
Documentation of shared decision-making result, utilizing an evidence-based tool, around the LAAC procedure from an independent, non-interventional physician	YES ☐
Fall history showing chronic and/or repeated falls	YES ☐
Documentation that patient has a chronic medical condition, occupation or lifestyle placing the patient at high risk for major bleeding	YES ☐
Attestation from the performing interventional cardiologist, electrophysiologist, or cardiac surgeon that he or she meets the training and ongoing cardiac procedure performance requirements (e.g., ≥25 previous procedures involving TSP)	YES ☐
Attestation that the patient – both pre-operatively and post-operatively – will be under the care of a cohesive, multidisciplinary team of medical professionals	YES ☐
Attestation that the patient is enrolled in, and the multidisciplinary team and hospital must participate in, a prospective, national, audited registry	YES ☐

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