PRIOR AUTHORIZATION REQUEST

HEMOPHILIA AGENTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or a CONTINUATION of therapy with the requested medication? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the requested medication? [] Hympavzi (If checked, go to 8) [] Alhemo (If checked, go to 20)		
8	What is the diagnosis or indication? [] Hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors or Hemophilia B (congenital factor IX deficiency) with factor IX inhibitors (If checked, go to 9) [] Hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors or Hemophilia B (congenital factor IX deficiency) without factor IX inhibitors (If checked, go to 10) [] Other (If checked, no further questions)		
9	Has documentation been submitted to confirm inhibitors to factor VIII with a current or historical titer of greater than or equal to 0.6 Bethesda Units (BU) or inhibitors to factor IX with a current or historical titer of greater than or equal to 0.6 Bethesda Units (BU)? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 11.] [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm the patient does not have a history of or currently have inhibitors to factor VIII or factor IX? [If no, no further questions.]	Yes	No
11	Is the patient 12 years of age or older?	Yes	No

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	[If no, no further questions.]		
12	Will the requested medication be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? [If no, no further questions.]	Yes	No
13	Does the provider attest that the patient does not have any known inherited or acquired coagulation disorder other than congenital hemophilia? [If no, no further questions.]	Yes	No
14	Does the patient have history of thromboembolic disease, considered at high risk of thromboembolic events, or undergoing current treatment for thromboembolic disease? [If yes, no further questions.]	Yes	No
15	Will the medication be used in combination with other agents for routine prophylaxis [e.g., factor replacement (Advate, Eloctate, BeneFIX, etc.), bypassing agent (NovoSeven, FEIBA, Sevenfact), nonfactor replacement therapy (emicizumab-kxwh (Hemlibra)), etc.]? [If yes, no further questions.]	Yes	No
16	Is the patient currently or planning to undergo Immune Tolerance Induction treatment? [If yes, no further questions.]	Yes	No
17	Has the patient previously received treatment with a gene therapy product (e.g., Hemgenix, Roctavian) for the treatment of hemophilia A or B? [If yes, no further questions.]	Yes	No
18	Is the requested medication prescribed by, or in consultation with, a hematologist? [If no, no further questions.]	Yes	No
19	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: Hympavzi: Loading dose: SUBQ: 300 mg single loading dose (as two 150 mg injections); Maintenance dose (begin 1 week after the loading dose): SUBQ: 150 mg once weekly (on the same day each week at any time of the day).] [No further questions.]	Yes	No
20	What is the diagnosis or indication? [] Hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors or Hemophilia B (congenital factor IX deficiency) with factor IX inhibitors (If checked, go to 21) [] Hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors or Hemophilia B (congenital factor IX deficiency) without factor IX inhibitors (If checked, go to 22)		

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	[] Other (If checked, no further questions)		
21	Has documentation been submitted to confirm inhibitors to factor VIII with a current or historical titer of greater than or equal to 0.6 Bethesda Units (BU) or inhibitors to factor IX with a current or historical titer of greater than or equal to 0.6 Bethesda Units (BU)? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
22	Has documentation been submitted to confirm the patient does not have a history of or currently have inhibitors to factor VIII or factor IX? [If no, no further questions.]	Yes	No
23	Is the patient 12 years of age or older? [If no, no further questions.]	Yes	No
24	Will the requested medication be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? [If no, no further questions.]	Yes	No
25	Does the provider attest that the patient does not have any known inherited or acquired coagulation disorder other than congenital hemophilia? [If no, no further questions.]	Yes	No
26	Does the patient have history of thromboembolic disease, considered at high risk of thromboembolic events, or undergoing current treatment for thromboembolic disease? [If yes, no further questions.]	Yes	No
27	Will the medication be used in combination with other agents for routine prophylaxis [e.g., factor replacement (Advate, Eloctate, BeneFIX, etc.), bypassing agent (NovoSeven, FEIBA, Sevenfact), nonfactor replacement therapy (emicizumab-kxwh (Hemlibra)), etc.]? [If yes, no further questions.]	Yes	No
28	Is the patient currently or planning to undergo Immune Tolerance Induction treatment? [If yes, no further questions.]	Yes	No
29	Has the patient previously received treatment with a gene therapy product (e.g., Hemgenix, Roctavian) for the treatment of hemophilia A or B? [If yes, no further questions.]	Yes	No
30	Is the requested medication prescribed by, or in consultation with, a hematologist? [If no, no further questions.]	Yes	No
31	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication?	Yes	No

maryland physicians care
Medicaid with a Heart

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[Dosing: Alhemo: 1 mg/kg once on day 1 (loading dose) then 0.2 mg/kg once daily starting on day 2; continue for 4 to 8 weeks, then maintenance dosage is based on plasma concentrations.]

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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