

ALHEMO

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Hemophilia A (factor VIII deficiency) with factor VIII inhibitors <input type="checkbox"/> Hemophilia B (factor IX deficiency) with factor IX inhibitors <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently being treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does this request include a loading dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ _____	
3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
4. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____	
5. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____ _____	
6. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., prescriber working in a hemophilia treatment center, hematologist with hemophilia experience) or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Will the requested agent be used as prophylaxis to prevent or reduce the frequency of bleeding episodes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Will the requested agent be used for the treatment of breakthrough bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Has the patient had previous prophylaxis therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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11. Will the patient be using the requested agent in combination with immune tolerance induction with clotting factor products (i.e., factor VIII or factor IX concentrates) are prophylactic therapy, hemophilia bypassing agent prophylaxis (i.e., factor VIIa or anti-inhibitor coagulant complex), or emicizumab for hemophilia A with inhibitors (Note: Factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds while receiving Alhemo)? Yes No
12. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max): _____

For Hemophilia A (factor VIII deficiency) with factor VIII inhibitors requests:

13. Has the diagnosis of congenital factor VIII deficiency been confirmed by blood coagulation testing? Yes No
14. Will the requested agent be used for ONE of the following? Yes No
 Primary prophylaxis in patients with severe factor VIII deficiency (factor VIII level of less than 1%)
 Secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints
15. If the patient has factor VIII inhibitors, does the patient have a current or historical inhibitor titer of greater than or equal to 5 Bethesda units (BU)? Yes No
16. Has the patient tried and had an inadequate response to Immune Tolerance Induction (ITI)? Yes No
 If no, are there medical records showing the patient has an inhibitor level greater than or equal to 200 BU? . Yes No
If yes, please submit medical records.
 If no, is there support for why the patient is not a candidate for ITI? Yes No
 If yes, please provide supporting information: _____

For Hemophilia A (factor VIII deficiency) without factor VIII inhibitors requests:

• **Please note, chart notes are required to support the answers to the following questions:**

17. Has the patient tried and had an inadequate response to TWO prerequisite agents? The prerequisite agents are: Hemlibra AND an antihemophilic factor VIII agent. Yes No
18. Were both Hemlibra AND an antihemophilic factor VIII agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
19. Does the patient have an FDA labeled contraindication to ALL prerequisite agents? The prerequisite agents are: Hemlibra AND ALL antihemophilic factor VIII agents..... Yes No
 If yes, please specify FDA labeled contraindication: _____

20. Does the patient have an intolerance or hypersensitivity to TWO prerequisite agents? The prerequisite agents are: Hemlibra AND an antihemophilic factor VIII agent. Yes No
 If yes, please explain intolerance/hypersensitivity: _____

21. Are both Hemlibra AND an antihemophilic factor VIII agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
22. Are both Hemlibra AND an antihemophilic factor VIII agent not in the best interest of the patient based on medical necessity?..... Yes No
23. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Hemlibra AND an antihemophilic factor VIII agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For Hemophilia B (factor IX deficiency) with factor IX inhibitors requests:

24. Has the diagnosis of congenital factor IX deficiency been confirmed by blood coagulation testing? Yes No
25. Will the requested agent be used for ONE of the following? Yes No
 Primary prophylaxis in patients with severe factor IX deficiency (factor IX level of less than 1%)
 Secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints
26. If the patient has factor IX inhibitors, does the patient have a current or historical inhibitor titer of greater than or equal to 5 Bethesda units (BU)? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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27. Has the patient tried and had an inadequate response to Immune Tolerance Induction (ITI)?..... Yes No
 If no, are there medical records showing the patient has an inhibitor level greater than or equal to 200 BU? . Yes No
If yes, please submit medical records.
 If no, is there support for why the patient is not a candidate for ITI?..... Yes No
 If yes, please provide supporting information: _____

For Hemophilia B (factor IX deficiency) without factor IX inhibitors requests:

• **Please note, chart notes are required to support the answers to the following questions:**

28. Has the patient tried and had an inadequate response to an antihemophilic Factor IX agent? Yes No
 29. Has an antihemophilic Factor IX agent been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 Does the patient have an FDA labeled contraindication to ALL antihemophilic Factor IX agents? Yes No
 If yes, please specify FDA labeled contraindication: _____
 30. Does the patient have an intolerance or hypersensitivity to an antihemophilic Factor IX agent? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
 31. Is an antihemophilic Factor IX agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 32. Is an antihemophilic Factor IX agent not in the best interest of the patient based on medical necessity?..... Yes No
 33. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as an antihemophilic Factor IX agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

34. Is there an absence of unacceptable toxicity from the drug (i.e., thromboembolic events, hypersensitivity, etc.)?..... Yes No
 35. Is the plasma concentration of concizumab at least 200 ng/mL? Yes No
 36. Has the patient had improvement or stabilization with the requested agent as indicated by the number of breakthrough bleeding episodes? **Please note, medical records are required.** Yes No
 If no, is there support for the continued use of the requested agent?
Please note, medical records are required. Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
Aetna/Cigna + Prime: 800.421.6022
BCBSIL/Prime: 888.802.8776

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