

# COAGULATION FACTOR VIIa 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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.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 diagnosis: <input type="checkbox"/> Hemophilia A <input type="checkbox"/> Hemophilia B <input type="checkbox"/> Congenital Factor VII deficiency <input type="checkbox"/> Glanzmann's thrombasthenia <input type="checkbox"/> Acquired hemophilia <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	On-demand quantity per month: Prophylactic quantity per month:
<b>For all requests:</b> 1. What is the patient's weight? _____ (kg) 2. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ 4. 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: _____ 5. Is the prescriber a specialist in the area of the patient's diagnosis [e.g., prescriber working in a hemophilia treatment center (HTC), 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 6. Will the patient be using the requested agent in combination with another Factor VIIa agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 7. 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: _____ 8. What is the requested agent being used for? <input type="checkbox"/> Prophylaxis <input type="checkbox"/> On-demand use for bleeds <input type="checkbox"/> Peri-operative management of bleeding <input type="checkbox"/> As a component of Immune Tolerance Therapy (ITT)/Immune Tolerance Induction (ITI)	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Is the requested dose within the FDA labeled dosing? **Please note, for on-demand requests, chart notes documenting frequency of bleeds are required.** .....  Yes  No  
 If no, is there clinical reasoning for the higher dosing? **Please note, medical records required.** .....  Yes  No
10. Is the requested quantity (number of doses) appropriate based on intended use (e.g., on-demand, prophylaxis, perioperative)? .....  Yes  No  
 If yes, please explain: \_\_\_\_\_
11. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_

**For Sevenfact requests:**

12. Has the prescriber communicated with the patient (via any means) regarding the frequency and severity of the patient's bleeds and has verified that the patient does not have greater than 5 on-demand doses on hand? .....  Yes  No  
 If no, please provide support for the patient having more than 5 on-demand doses on hand: \_\_\_\_\_

**For on-demand use for bleeds requests:**

13. Has the prescriber communicated with the patient (via any means) regarding the frequency and severity of the patient's bleeds and has verified that the patient does not have greater than 5 on-demand doses on hand? .....  Yes  No  
 If no, please provide support for the patient having more than 5 on-demand doses on hand: \_\_\_\_\_

**For hemophilia A and hemophilia B requests:**

14. Does the patient have inhibitors to Factor IX? .....  Yes  No
15. Does the patient have inhibitors to Factor VIII? .....  Yes  No
16. Is the requested agent being used for prophylaxis? .....  Yes  No  
 If yes, will the patient be using the requested agent in combination with Hemlibra? .....  Yes  No  
 If yes, has the patient tried and had an inadequate response to Immune Tolerance Induction (ITI) [Immune Tolerance Therapy (ITT)]? .....  Yes  No  
 If no, does the patient have an inhibitor level greater than or equal to 200 BU? **Please note, lab records are required.** .....  Yes  No  
 If no, is there information indicating why the patient is not a candidate for ITI? .....  Yes  No
17. Is the requested agent being used as a component of Immune Tolerance Therapy (ITT)/Immune Tolerance Induction (ITI)? .....  Yes  No  
 If yes, has the patient had more than 33 months of ITT/ITI therapy? .....  Yes  No  
 If yes, is there information supporting the continued use of ITT/ITI therapy (i.e., the patient has had a greater than or equal to 20% decrease in inhibitor level over the last 6 months and needs further treatment to eradicate inhibitors)? **Please submit medical records.** .....  Yes  No  
 If no, how many months of ITT therapy has the patient had? \_\_\_\_\_

**For Glanzmann's thrombasthenia requests:**

18. Is the patient refractory to platelet transfusions? .....  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**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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