

FACTOR VIII AND VON WILLEBRAND FACTOR PRIOR AUTHORIZATION 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 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's Diagnosis: <input type="checkbox"/> Hemophilia A (also known as Factor VIII deficiency or classic hemophilia) <input type="checkbox"/> von Willebrand disease (VWD) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
- What is the patient's weight? _____ (kg)
 - Is the patient currently treated with the requested agent? Yes No
 - Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____
 - Is the requested dose within FDA labeling? Yes No
 If no, is there support for exceeding the defined program quantity limit (dose and/or number of doses)?
Please note, medical records required Yes No
 - Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
 - Will the patient be using the requested agent with another agent in combination within the same category (e.g., Factor VIII agents, Factor VIII and von Willebrand Factor combination agents) included in this program? The target agents for this program are: Advate, Adynovate, AfstylA, Alphanate, Altuviio, Elocate, Esperoct, Hemofil m, Humate-p, Jivi, Koate, Koate-dvi, Kogenate fs, Kovaltry, Novoeight, Nuwiq, Recombinate, Vonvendi, Wilate, Xyntha, Xyntha solofuse Yes No
 If yes, is there support for the use of more than one unique agent in the same category? **Please note, medical records are required** Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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7. 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? Yes No
8. Is the patient currently experiencing a bleed, out of medication, and needs a one-time emergency supply of medication? Yes No
9. Will the requested agent be used for any of the following? **Please select all that apply.**
 Prophylaxis Peri-operative management of bleeding On-demand use for bleeds
 Immune Tolerance Therapy (ITT)/Immune Tolerance Induction (ITI)
10. How many prophylaxis doses are being requested per month? _____
11. How many on-demand doses are being requested per month? _____
12. How many total doses are being requested per month? _____
13. How many total units are being requested per month? _____
14. Please provide information supporting the requested dose, including ALL of the following:
 Actual prescribed dose: _____
 Inhibitor status: _____
 Severity of the factor deficiency (i.e., severe is less than 1% factor activity, moderate is greater than or equal to 1 to less than or equal to 5% factor activity, mild is greater than 5 to 40% factor activity): _____
15. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide rationale in support for using the requested agent for the patient's age for the requested indication: _____
16. 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 Hemophilia A requests:

17. Will the patient use the requested agent in combination with Hemlibra (emicizumab-kxwh)? Yes No
18. If the requested agent is being used for immune tolerance therapy (ITT)/immune tolerance induction (ITI), has the patient had more than 33 months of ITT/ITI therapy? **Please note, medical records are required.** Yes No
If yes, is there support for 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 note, medical records are required.** Yes No

For von Willebrand Disease (VWD) requests:

19. Does the patient have type 2B or 3 VWD? Yes No
If yes, does the patient have severe Type 3 VWD? Yes No
20. Does the patient have type 1, 2A, 2M, or 2N VWD? Yes No
21. Has the patient tried and had an inadequate response to desmopressin (e.g., DDAVP injection)? Yes No
22. Has the patient had a poor response to a DDAVP trial with 1 and 4 hour post infusion bloodwork? Yes No
23. Does the patient have an intolerance or hypersensitivity to desmopressin? Yes No
If yes, please explain intolerance/hypersensitivity: _____
24. Does the patient have an FDA labeled contraindication to desmopressin? Yes No
If yes, please specify FDA labeled contraindication: _____
25. Is there support showing why the patient cannot use desmopressin (e.g., shortage in marketplace)? Yes No
If yes, please provide support: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>For renewal requests:</p> <p>26. Has the prescriber communicated with the patient regarding the frequency and severity of the patient's bleeds and has verified that the patient does not have more than 5 on-demand doses on hand? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for the patient having more than 5 on-demand doses on hand? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide support: _____</p> <p>27. If the requested agent is being used for immune tolerance therapy (ITT)/immune tolerance induction (ITI), has the patient had more than 33 months of ITT/ITI therapy? Please note, medical records are required. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there support for 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 note, medical records are required. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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