

HEMLIBRA

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 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:

- Hemophilia A with Factor VIII inhibitors (hemophilia A with inhibitors)
- Hemophilia A without Factor VIII inhibitors (hemophilia A) OR an inhibitor level < 5
- Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
1. What is the patient's weight? _____ (kg)
 2. Is the patient currently treated with the requested agent? Yes No
 3. 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: _____
 4. Is the prescriber a specialist in the area of the patient's diagnosis [e.g., prescriber working in hemophilia center (HCT), hematologist with hemophilia experience], or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
 5. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
 6. Will the requested agent be used as prophylaxis to prevent or reduce the frequency of bleeding episodes? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For all requests continued:

7. What type of regimen is the patient requesting? Select ALL that apply and complete corresponding questions.

Induction therapy

Please provide the patient's total INDUCTION dose in milligrams (mg): _____

What are the vial sizes and quantities being requested to meet the patient's induction regimen? Select ALL that apply.

- 12mg/0.4mL (Please specify quantity of vials) _____
- 30mg/1mL (Please specify quantity of vials) _____
- 60mg/0.4mL (Please specify quantity of vials) _____
- 105mg/0.7mL (Please specify quantity of vials) _____
- 150mg/1mL (Please specify quantity of vials) _____
- 300mg/2mL (Please specify quantity of vials) _____

Maintenance therapy

Please provide the patient's total MAINTENANCE dose in milligrams (mg) and FREQUENCY (every X weeks):

What are the vial sizes and quantities being requested to meet the patient's maintenance regimen? Select ALL that apply.

- 12mg/0.4mL (Please specify quantity of vials) _____
- 30mg/1mL (Please specify quantity of vials) _____
- 60mg/0.4mL (Please specify quantity of vials) _____
- 105mg/0.7mL (Please specify quantity of vials) _____
- 150mg/1mL (Please specify quantity of vials) _____
- 300mg/2mL (Please specify quantity of vials) _____

For initial requests:

8. Will the patient be using the requested agent in combination with any of the following while on maintenance dosing with the requested agent?

- 1) Prophylaxis with a Factor VIIa product (e.g., NovoSeven RT)
- 2) Prophylaxis with a Factor VIII product (e.g., Advate, Adynovate, Eloctate, Nuwiq, Recombinate, Xyntha)
- 3) Prophylaxis with a bypassing agent (e.g., Feiba, NovoSeven)
- 4) Immune tolerance therapy (ITT) (immune tolerance induction, ITI)] Yes No

9. Is the patient receiving Feiba [activated prothrombin complex concentrate (aPCC)] for breakthrough bleeds? ... Yes No

If yes, will the patient be monitored for thrombotic microangiopathy and thromboembolism? Yes No

If yes, has the prescriber counseled the patient on the maximum dosages of Feiba to be used (i.e., no more than 100 units/kg/24 hours)? Yes No

For renewal requests:

10. Has the patient had improvements or stabilization with the requested agent as indicated by the number of breakthrough bleeds as reported in the treatment log and/or chart notes? **Please note, medical records**

including treatment log and/or chart notes 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

11. Is the patient receiving Feiba [activated prothrombin complex concentrate (aPCC)] for breakthrough bleeds? ... Yes No

If yes, will the patient be monitored for thrombotic microangiopathy and thromboembolism? Yes No

12. Will the patient be using the requested agent in combination with any of the following?

- 1) Prophylaxis with a Factor VIIa product (e.g., NovoSeven RT)
- 2) Prophylaxis with a Factor VIII product (e.g., Advate, Adynovate, Eloctate, Nuwiq, Recombinate, Xyntha)
- 3) Prophylaxis with a bypassing agent (e.g., Feiba, NovoSeven)
- 4) Immune tolerance therapy (ITT) (immune tolerance induction, ITI)] Yes No

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