

# HEMOPHILIA FACTOR IX 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](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’s Diagnosis <input type="checkbox"/> Hemophilia B (also known as Factor IX deficiency, Christmas disease) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength(s):
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 treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the patient been treated with the requested agent (starting on samples is not approvable) within the past 90 days? ..... <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 explain: _____ _____ 4. Is the patient currently experiencing a bleed AND BOTH of the following: 1) the patient is out of medication AND 2) the patient needs to receive a ONE TIME emergency supply of medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. What is the requested agent being prescribed for? <input type="checkbox"/> Prophylaxis <input type="checkbox"/> On-demand use for bleeds <input type="checkbox"/> Peri-operative management of bleeding 6. What is the actual prescribed dose? _____ • How many total units are being requested per month? _____ • What is the 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)? _____ • What is the inhibitor status? _____ 7. 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: _____ _____	
<b>Please continue to the next page.</b>	

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

- 8. Is the patient's age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
If no, please provide support for using the requested agent for the patient's age for the requested indication: \_\_\_\_\_
- 9. Will the patient be using the requested agent in combination with another Factor IX agent included in this program (e.g., AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine, Profilnine SD, Rebinyn, Rixubis)? .....  Yes  No  
If yes, is there information supporting the use of more than one unique Factor IX agent? **Please note, medical records are required.** .....  Yes  No
- 10. 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
- 11. Is the requested quantity (dose) within the FDA labeled dose? .....  Yes  No  
If yes, is the requested quantity (number of doses) appropriate based on intended use (e.g., prophylaxis, on-demand, peri-operative)? .....  Yes  No  
If yes, please explain: \_\_\_\_\_
- 12. Is there clinical reasoning for exceeding the defined program quantity limit (dose and/or number of doses)? .....  Yes  No  
**If yes, please provide medical records supporting the higher dose.**
- 13. 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 renewal requests:**

- 14. 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 less than 5 on-demand doses on hand?.....  Yes  No  
If no, provide information in support of the patient having more than 5 on-demand doses on hand: \_\_\_\_\_  
\_\_\_\_\_

**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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