

HYMPAVZI

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 (factor VIII deficiency) without factor VIII inhibitors
- Hemophilia B (factor IX deficiency) without factor IX inhibitors
- 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 being treated with the requested agent?..... Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.**..... 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 explain risk: _____
 4. Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
 If yes, please specify contraindications: _____
 5. 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: _____
 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?..... Yes No

Please continue to the next page.

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

7. Will the requested agent be used in combination with clotting factor products (i.e., factor VIII or factor IX concentrates) being used as prophylactic therapy (Note: factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds while receiving Hympavzi)?..... Yes No
8. Will the requested agent be used as prophylaxis to prevent or reduce the frequency of bleeding episodes? Yes No
9. Will the requested agent be used for the treatment of breakthrough bleeding? Yes No
10. Is the patient pregnant?..... Yes No
11. Is the requested quantity (dose) 300 mg once weekly for maintenance dosing? Yes No
 If yes, has the patient tried and had an inadequate response (i.e., inadequate control of bleeding episodes) with the maintenance dosing of 150 mg once weekly? **Please note, medical records are required.** Yes No
12. 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 (factor VIII deficiency) without factor VIII inhibitors requests:

- **Please submit medical records or chart notes to support the answers to the following questions:**

13. Are there medical records showing the requested agent will be used for ONE of the following: 1) primary prophylaxis in patients with severe factory VIII deficiency (factor VIII level of less than 1%), or 2) secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints? Yes No
14. Has the patient tried and had an inadequate response to TWO prerequisite agents (i.e., Hemlibra AND an antihemophilic factor VIII agent)?..... Yes No
15. Has the patient tried and had an inadequate response to ONE prerequisite agent (i.e., Hemlibra or an antihemophilic factor VIII agent) AND an intolerance or hypersensitivity to the ONE OTHER prerequisite agent?..... Yes No
16. Does the patient have an intolerance or hypersensitivity to TWO prerequisite agents (i.e. Hemlibra AND an antihemophilic factor VIII agent)?..... Yes No
17. Does the patient have an FDA labeled contraindication to BOTH Hemlibra AND ALL antihemophilic factor VIII agents?..... Yes No
18. Were TWO prerequisite agents (i.e., Hemlibra AND an antihemophilic factor VIII agent) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
19. Are TWO prerequisite agents (i.e. 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
20. Are TWO prerequisite agents (i.e., Hemlibra AND an antihemophilic factor VIII agent) NOT in the best interest of the patient based on medical necessity?..... Yes No
21. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO prerequisite agents (i.e., 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

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For hemophilia B (factor IX deficiency) without factor IX inhibitors requests:

- **Please submit medical records or chart notes to support the answers to the following questions:**

22. Are there medical records showing the requested agent will be used for ONE of the following: 1) primary prophylaxis in patients with severe factor IX deficiency (factor IX level of less than 1%), or 2) secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints? Yes No
23. Has the patient tried and had an inadequate response to an antihemophilic factor IX agent? Yes No
24. Does the patient have an intolerance or hypersensitivity to an antihemophilic factor IX agent? Yes No
25. Does the patient have an FDA labeled contraindication to ALL antihemophilic factor IX agents? Yes No
26. Was an antihemophilic factor IX agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
27. 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
28. Is an antihemophilic factor IX agent not in the best interest of the patient based on medical necessity? Yes No
29. 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:

30. Are there medical records showing the patient has 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, are there medical records showing there is 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**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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