

# QFITLIA

## 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's Diagnosis:	
<input type="checkbox"/> Hemophilia A (factor VIII deficiency) <input type="checkbox"/> Hemophilia B (factor IX deficiency) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
1. 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
  2. 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: \_\_\_\_\_
  3. Does the patient have any FDA labeled contraindications to the requested agent?.....  Yes  No  
 If yes, please specify contraindications: \_\_\_\_\_
  4. 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
  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. Will the requested agent be used in combination with immune tolerance induction with clotting factor products (i.e., factor VIII or factor IX concentrates) as prophylactic therapy, hemophilia bypassing agent prophylaxis (i.e., factor VIIa or anti-inhibitor coagulant complex), or Emicizumab for hemophilia A with inhibitors (Note: Factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds when occurring more than 7 days after initiation of QFITLIA)?.....  Yes  No
  7. Does the patient have a co-existing thrombophilic disorder or a history of, or risk factors predisposing to, thrombosis?.....  Yes  No
  8. Will the requested agent be used for the treatment of breakthrough bleeding? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Does the patient have an antithrombin (AT) activity level of greater than or equal to 60% at baseline (e.g., prior to therapy with the requested agent) and AT-activity will be monitored regularly as outlined in the FDA labeling? .....  Yes  No
10. Does the patient have hepatic impairment (Child-Pugh Class A, B, and C)? .....  Yes  No
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 Hemophilia A (factor VIII deficiency) requests:**

12. Does the patient have a diagnosis of congenital factor VIII deficiency confirmed by blood coagulation testing? .  Yes  No
13. Will the requested agent be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? .....  Yes  No
14. Will the requested agent be used for ONE of the following? .....  Yes  No
- Primary prophylaxis in patients with severe factor VIII deficiency (factor VIII level of less than 1%)
- Secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints
15. Does the patient have factor VIII inhibitors? .....  Yes  No
- If yes, has the patient had previous prophylaxis therapy? .....  Yes  No
- If yes, has the patient tried and had an inadequate response to Immune Tolerance induction (ITI)? .....  Yes  No
- If no, are there medical records showing the patient has an inhibitor level of greater than or equal to 200 BU? **Please note, medical records are required.** .....  Yes  No
- If no, is there support for why the patient is NOT a candidate for ITI?.....  Yes  No
- If yes, please provide supporting information: \_\_\_\_\_

**For Hemophilia A (factor VIII deficiency) without factor VIII inhibitors requests:**

• **Please note, chart notes are required to support the answers to the following questions:**

16. Has the patient tried and had an inadequate response to TWO prerequisite agents? The prerequisite agents are: Hemlibra AND an antihemophilic factor VIII agent. ....  Yes  No
17. Were both Hemlibra AND an antihemophilic factor VIII agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
18. Does the patient have an FDA labeled contraindication to ALL prerequisite agents? The prerequisite agents are: Hemlibra AND ALL antihemophilic factor VIII agents .....  Yes  No
- If yes, please specify FDA labeled contraindication: \_\_\_\_\_
19. Does the patient have an intolerance or hypersensitivity to TWO prerequisite agents? The prerequisite agents are: Hemlibra AND an antihemophilic factor VIII agent. ....  Yes  No
- If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_
20. Are both 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
21. Are both Hemlibra AND an antihemophilic factor VIII agent not in the best interest of the patient based on medical necessity? .....  Yes  No
22. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as 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

**For Hemophilia B (factor IX deficiency) requests:**

23. Does the patient have a diagnosis of congenital factor IX deficiency confirmed by blood coagulation testing? ...  Yes  No
24. Will the requested agent be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? .....  Yes  No
25. Will the requested agent be used for ONE of the following? .....  Yes  No
- Primary prophylaxis in patients with severe factor IX deficiency (factor IX level of less than 2%)
- Secondary prophylaxis in patients with at least TWO episodes of spontaneous bleeding into joints

**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) requests continued:**

26. Does the patient have factor IX inhibitors? .....  Yes  No  
 If yes, has the patient had previous prophylaxis therapy? .....  Yes  No  
 If yes, has the patient tried and had an inadequate response to Immune Tolerance induction (ITI)? .....  Yes  No  
 If no, are there medical records showing the patient has an inhibitor level of greater than or equal to 200 BU? **Please note, medical records are required.** .....  Yes  No  
 If no, is there support for why the patient is NOT a candidate for ITI? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_

**For Hemophilia B (factor IX deficiency) without factor IX inhibitors requests:**

**Please note, chart notes are required to support the answers to the following questions:**

27. Has the patient tried and had an inadequate response to an antihemophilic Factor IX agent? .....  Yes  No  
 28. Has an antihemophilic Factor IX agent been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No  
 Does the patient have an FDA labeled contraindication to ALL antihemophilic Factor IX agents? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 29. Does the patient have an intolerance or hypersensitivity to an antihemophilic Factor IX agent? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 30. 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  
 31. Is an antihemophilic Factor IX agent not in the best interest of the patient based on medical necessity? .....  Yes  No  
 32. 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:**

33. 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 supporting 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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