Coagadex

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: _________________________*kg*

Patient Height: _________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical (POS Code 24)* ❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)* ❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

What is the ICD-10 code? ___________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Coagadex SGM 1942-A – 11/2023.

Criteria Questions:

1. What is the diagnosis?

❒ Hereditary factor X deficiency, *Continue to 2*

❒ Other, please specify. _________________________, *Continue to 2*

2. For which of the following is Coagadex being requested?

❒ Prophylaxis to reduce the frequency of bleeding episodes, *Continue to 4*

❒ On-demand treatment and control of bleeding episodes, *Continue to 4*

❒ Perioperative management of bleeding, *Continue to 3*

❒ None of the above, *No further questions*

3. Does the patient have mild, moderate, or severe hereditary Factor X deficiency?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. Is the request for continuation of therapy?

❒ Yes, *Continue to 5*

❒ No, *No Further Questions*

5. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org