Factor VIII Agents

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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering 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.

Required Demographic Information:

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)*

Drug Information:

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

What is the ICD-10 code? _____

Criteria Questions:

What drug is being prescribed?

❑ Advate ❑ Adynovate ❑ Afstyla ❑ Altuviiio ❑ Eloctate ❑ Esperoct
❑ Hemofil M ❑ Kogenate FS ❑ Kovaltry ❑ Novoeight ❑ Nuwiq
❑ Recombinate ❑ Xyntha ❑ Other _____

1. What is the diagnosis?

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

❒ Hemophilia A, *Continue to #2*

❒ Other, *Continue to #2*

2. Is the requested medication prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to #10*

❒ No, *Continue to #4*

4. What is the patient's baseline factor VIII assay level (% activity)?

❒ Less than 1% to 5% (moderate or severe disease), *No Further Questions*

❒ Greater than 5% (mild disease), *Continue to #5*

5. Has the patient had an insufficient response to desmopressin?

❒ Yes, *No Further Questions*

❒ No, *Continue to #6*

6. Is there a clinical reason for not trying desmopressin first?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. What is the reason? Please indicate the clinical reason for not trying desmopressin first

❒ Age less than 2 years, *No Further Questions*

❒ Pregnancy, *No Further Questions*

❒ Fluid/electrolyte imbalance, *No Further Questions*

❒ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No Further Questions*

❒ Predisposition to thrombus formation, *No Further Questions*

❒ Trauma requiring surgery, *No Further Questions*

❒ Life-threatening bleed, *No Further Questions*

❒ Contraindication or intolerance to desmopressin, *No Further Questions*

❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No Further Questions*

❒ Other, *No Further Questions*

Continuation

10. 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 Priority Partners.

X_____

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

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

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

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com