JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Hemlibra

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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

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

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Hemophilia A (congenital factor VIII deficiency), *Continue to 2*
❒ Acquired hemophilia A, *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

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

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 4*
❒ No, *Continue to 6*

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the patient use the requested medication for prophylactic use in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

6. Is the requested medication being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's baseline factor VIII assay level (% activity)?
❒ Less than 1% to 5% (moderate or severe disease), *Continue to 11*
❒ Greater than 5% (mild disease), *Continue to 8*

8. Has the patient had an insufficient response to desmopressin?
❒ Yes, *Continue to 11*
❒ No, *Continue to 9*

9. Is there a clinical reason for not trying desmopressin first?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the reason? Please indicate the clinical reason for not trying desmopressin first.
❒ Age less than 2 years, *Continue to 11*
❒ Pregnancy, *Continue to 11*
❒ Fluid/electrolyte imbalance, *Continue to 11*
❒ High risk for cardiovascular or cerebrovascular disease (especially the elderly), *Continue to 11*
❒ Predisposition to thrombus formation, *Continue to 11*
❒ Trauma requiring surgery, *Continue to 11*

❒ Life-threatening bleed, *Continue to 11*

❒ Contraindication or intolerance to desmopressin, *Continue to 11*

❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *Continue to 11*

❒ Other, please specify. _____, *Continue to 11*

11. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

12. What is the patient's body weight in kilograms?

❒ Any weight; please specify: _____, *Continue to 13*

❒ Unknown, *Continue to 13*

13. What is the prescribed induction dose in milligrams (mg)?

❒ Any dose; please specify: _____, *Continue to 14*

❒ Unknown, *Continue to 14*

14. Is the prescribed frequency more frequent than once weekly for the first 4 weeks?

❒ Yes, *Continue to 15*

❒ No, *Continue to 15*

15. Does the prescribed induction dose exceed 3 mg/kg subcutaneously for the first 4 weeks?

Please calculate dose from responses to questions #12 and #13.

❒ Yes, *Continue to 17*

❒ No, *Continue to 17*

16. What is the patient's body weight in kilograms (kg)?

❒ Any weight; please specify: _____, *Continue to 17*

❒ Unknown, *Continue to 17*

17. What is the prescribed maintenance dose in milligrams (mg)?

❒ Any dose; please specify: _____, *Continue to 18*

❒ Unknown, *Continue to 18*

18. What is the prescribed frequency for the maintenance dose?

❒ Once every week, *Continue to 19*

❒ Once every two weeks, *Continue to 20*

❒ Once every four weeks, *Continue to 21*

❒ Other, please specify. _____, *No Further Questions*

19. Does the prescribed maintenance dose exceed 1.5 mg/kg?

Please calculate dose from responses to questions #16 and #17.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

20. Does the prescribed maintenance dose exceed 3 mg/kg?

Please calculate dose from responses to questions #16 and #17.

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Does the prescribed maintenance dose exceed 6 mg/kg?

Please calculate dose from responses to questions #16 and #17.

❒ 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