# RiaSTAP

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

**<u>Drug Information:</u>**
*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

**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. RiaSTAP SGM 2983-A – 04/2023.

**Clinical Criteria Questions:**

What is the ICD-10 code? __________

1. What is the diagnosis?

❒ Congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia, *Continue to 2*

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

2. Is RiaSTAP being requested for the treatment of acute bleeding episodes?
❒ Yes, *No Further Questions*
❒ No, *Continue to 3*

3. Does the patient have a diagnosis of afibrinogenemia?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Will RiaSTAP be used for perioperative management of bleeding?
❒ Yes, *No Further Questions*
❒ No, *Continue to 5*

5. Will RiaSTAP be used for prophylaxis to reduce the frequency of bleeding episodes? ***ACTION REQUIRED***: If Yes, attach justification from the patient's medical records.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the request for continuation of therapy?
❒ Yes, *Continue to 7*
❒ No, *No Further Questions*

7. Is the patient experiencing benefit from therapy (e.g., reduced frequency of bleeding episodes)?
❒ 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)**

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