MEDICA®

Hemophilia Product Prior Authorization Form

Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries and **fax to 1-888-656-0841** or **call 1-800-424-7892**. All lab results must be faxed in.

This request form pertains to the following products:

Feiba	Helixate FS	Alphanate	Hemlibra	Wilate
Feiba NF	Kogenate FS	Humate-P	BeneFIX	Idelvion
NovoSeven RT	Novoeight	AlphaNine SD	Ixinity	Vonvendi
Hemofil M	Recombinate	Mononine	Rixubis	Afstyla
Koate-DVI	Xyntha	Bebulin	Alprolix	
Monoclate-P	Adynovate	Kovaltry	Coagadex	
Nuwiq	Eloctate	Profilnine	Corifact	
Advate	Obizur	Rebinyn	Tretten	

I. Demographic Information

Patient Information		
First Name	Last Name	Patient Gender
Patient DOB	Patient Phone #	Alternative Phone #
Patient Address:		
City	State	Zip code
Provider Information		
Prescriber Name	Contact Name	Contact Phone #
NPI	Fax #	
Prescriber Address:		
City	State	Zip code

Magellan Rx MANAGEMENT℠

Rendering Provider (Dispensing Pharmacy) Information		
Pharmacy Name	NPI	NABP
Contact Name	Phone #	Fax #

Insurance Information	
Policy Holder Name	ID# of Insurance Card
Name of Insurance Company	Group #

Primary Diagnosis

- ☐ Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- ☐ Acquired Hemophilia A (Aquired Factor VIII Deficiency)
- ☐ Hemophilia B (Congenital Factor IX Deficiency)
- ☐ von Willebrand Disease
- ☐ Congenital Factor XIII Deficiency
- ☐ Congenital Factor XIII A-subunit Deficiency
- ☐ Hereditary Factor X Deficiency
- ☐ Congenital Factor VII Deficiency
- ☐ Glanzmann's Thrombasthenia

ICD 10 Code

Patient Inventory (Medication on Hand)		
Total Number of Doses on Hand	Total Units on Hand (IU)	Date Verified

Clinical Information

Name of Treating Facility

Treatment status	Product Name
☐ Treatment-naïve ☐ Treatment-experienced	

Was the patient on a different factor product previously?

☐ Yes
☐ No

If yes, which product and reason for product switching:_____

_____

Member's Height	Member's Weight	Severity of Disease
		☐ Mild (6% to 25% factor level) ☐ Moderate (1% to 5% factor level) ☐ Severe (< 1% factor level)

Dose (IU)	Number of Doses Requested	Total Dose Requested (IU)

Dosing Instructions	Retrospective request?
	☐ Yes ☐ No

Type of Use (Check all that applies)	Place of Administration:
☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure Date of Procedure:_____ ☐ Surgical Prophylaxis Date of Procedure:_____	☐ Home infusion ☐ Outpatient Hemophilia Treatment Center (HTC) ☐ Outpatient Hospital ☐ Provider's office ☐ Self-administration

Number and Location of bleeds in the past 12 months:

Does the patient have a diagnosis confirmed by blood coagulation testing?

☐ Yes
☐ No

Please provide the following information regarding factor levels

- ☐ Factor VIII for Hemophilia A
- ☐ Factor IX for Hemophilia B
- ☐ Factor X for Hereditary Factor X Deficiency
- ☐ Factor XIII for Congenital Factor XIII or Factor XXIII A-subunit Deficiencies
- ☐ VW Factor for von Willebrand Disease

a. Baseline Factor Level _____

b. Date of Factor Level_____

c. Desired (Target) Factor Level_____

Does the patient have inhibitors to factor products?

- ☐ Yes
- ☐ No

If so, are documentations of inhibitor tests attached? (e.g., Bethesda inhibitor assay)

- ☐ Yes
- ☐ No

Has the patient previously received Immune Tolerance Induction (ITI)?

- ☐ Yes
- ☐ No

If yes, date and duration of the trial and patient response: _____

_____

Did the patient experience at least two documented episodes of spontaneous bleeding into the joints?

- ☐ Yes
- ☐ No

For minimally treated patients (< 50 exposure days to factor products) previously receiving a different factor product, how often will inhibitor testing be performed?

_____

Was a pharmacokinetics (PK) test performed for this patient?

- ☐ Yes
- ☐ No

If so, are PK testing results attached?

- ☐ Yes
- ☐ No

If patient has a diagnosis of Glanzmann's Thrombasthenia, has the patient tried platelet transfusions?

- ☐ Yes
- ☐ No

If yes, date of the trial and patient response: _____

If the patient has a diagnosis of von Willebrand Disease (VWD), has the patient tried desmopressin?

- ☐ Yes
- ☐ No

If no, is the patient contraindicated to desmopressin?

- ☐ Yes
- ☐ No

If yes, what is the reason for contraindication:_____

For acute bleeding episodes, please provide the following additional information:

Location of Bleed	Type of Bleed	Start Date of Bleed:	End Date of Bleed:
	☐ Minor ☐ Moderate ☐ Major		

Number of Doses Used	Dose (IU)	Total Amount Used (IU)