

ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antihemophilia Agents** are available on the DHS Pharmacy Services website at:
<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/State/Zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:		
Directions:	Quantity:	Duration:	
Drug #2 requested:	Strength & package size:		
Directions:	Quantity:	Duration:	
Diagnosis (<i>submit documentation</i>):			Dx code (<i>required</i>):
Is the medication being prescribed by a hematologist or hemophilia treatment center practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL REQUESTS

- For HEMLIBRA (emicizumab):**
 - Has a diagnosis of severe hemophilia A **AND**
 - Failed to achieve clinical goals with or has a contraindication or intolerance to routine FVIII replacement prophylaxis
 - Has been using Hemlibra in the past 90 days
 - Has a diagnosis of severe hemophilia A with inhibitors
- For a BYPASSING AGENT (eg, FEIBA NF, Novoseven):**
 - For routine prophylaxis:**
 - Has hemophilia A with inhibitors **AND** (*check all that apply*):
 - Failed to achieve clinical goals with Hemlibra
 - Has a medical reason why Hemlibra cannot be used
 - Has been using the requested bypassing agent for routine prophylaxis within the past 90 days
 - Has hemophilia B with inhibitors
 - For use other than routine prophylaxis (e.g., episodic/on-demand treatment, intermittent/periodic prophylaxis):**
 - Has hemophilia A with inhibitors OR has hemophilia B with inhibitors
- For a non-preferred FACTOR VIII, FACTOR IX, or VWF:**
 - Has been using the requested product within the past 90 days AND has a medical reason to continue using the requested product
 - Failed to achieve clinical goals with or has a contraindication or intolerance to the preferred FVIII, FIX, or FVIII/VWF products *Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*

RENEWAL REQUESTS

- Experienced a positive clinical response since starting the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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