pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

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.

☐New request ☐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:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:	
Directions:	Quantity:	Refills:
Drug #2 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Is the medication prescribed by a hematologist or hemophilia treatment center practitioner? ☐Yes ☐No		

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

INITIAL REQUESTS

1. Request is for HEMLIBRA (emicizumab):
   - ☐Has a diagnosis of severe hemophilia A
   - ☐Has a diagnosis of severe hemophilia A with inhibitors
   - ☐Has a diagnosis of hemophilia A and a history of at least 1 spontaneous joint bleed or other serious bleeding event

2. Request is for a BYPASSING AGENT (eg, FEIBA NF, NovoSeven, Sevenfact) *(check all that apply)*:
   - ☐Has hemophilia A with inhibitors:
     - ☐Is using the requested medication for episodic/on-demand treatment OR intermittent/periodic prophylaxis
     - ☐Is using the requested medication for routine prophylaxis
       - ☐Failed to achieve clinical goals with Hemlibra

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☐ 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

☐ Has acquired hemophilia

☐ Has congenital factor VII deficiency

☐ Has Glanzmann's thrombasthenia

3. Request is for a non-preferred FACTOR VIII, FACTOR IX, or VWF:

☐ Both of the following:

☐ Has been using the requested product within the past 90 days

☐ Has a medical reason to continue using the requested medication

☐ Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred FVIII, FIX, or FVIII/VWF products with the same half-life (standard v. extended half-life), if applicable. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

☐ Has a diagnosis for which no preferred Antihemophilia Agents are appropriate. *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: