HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
HEMOPHILIA AND BLOOD PRODUCTS

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

HEMOPHILIA A AGENTS

☐ Advate® (antihemophilic factor (recombinant), ☐ Alphanate® (antihemophilic factor (human), ☐ Desmopressin (DDAVP), ☐ Helixate FS® (antihemophilic factor (recombinant), ☐ Hemlibra® (emicizumab), ☐ Hemofil M® (antihemophilic factor (human), ☐ Humate-P® (antihemophilic factor (human), ☐ Koate-DVI® (antihemophilic factor (human), ☐ Kogenate FS® (antihemophilic factor (recombinant), ☐ Kovaltry® (antihemophilic factor (recombinant), ☐ Monoclate-P® (antihemophilic factor (human), ☐ Novoeight® (antihemophilic factor (recombinant), ☐ Novoseven RT® (coagulation factor VIIa (recombinant), ☐ Obizur (antihemophilic factor (recombinant), ☐ Recombinate® (antihemophilic factor (recombinant), ☐ Wilate® (antihemophilic factor (human), ☐ Xyntha® (antihemophilic factor (recombinant)

Long-Acting Products: ☐ Adynovate® (antihemophilic factor (recombinant), ☐ Afstyla® (antihemophilic factor (recombinant), ☐ Eloctate™(antihemophilic factor (recombinant)

HEMOPHILIA B AGENTS

☐ Alphanine SD® (coagulation Factor IX), ☐ Benefix® (coagulation factor IX (recombinant), ☐Mononine® (coagulation Factor IX), ☐ Ixinity® (coagulation factor IX (recombinant), ☐ Profilnine® (factor IX complex), ☐ Rixubis® (coagulation factor IX (recombinant)),

Long-Acting Products: ☐ Alprolix™ (coagulation factor IX (recombinant))

VON WILLEBRAND DISEASE (VWD) AGENTS

☐ Alphanate® (antihemophilic factor (human), ☐ Stimate® (Desmopressin (DDAVP), ☐ Humate-P® (antihemophilic factor (human), ☐ Wilate (coagulation factor VIII complex (human)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Does the member have a diagnosis of moderate or severe hemophilia A, hemophilia B, or laboratory confirmed diagnosis of type 2B or type 3 Von Willebrand's disease?	☐	☐	**Please provide documentation**

2. For members with mild hemophilia A OR type 1, 2A, 2M, or 2N Von Willebrand Disease, has the member tried and failed, or has a contraindication/intolerance, or a clinical reason for not using desmopressin (DDAVP)?	☐	☐	**Please provide documentation**
3. Is the request made by, or in consultation with, a hematologist?	☐	☐	
4. Will the request be made for one of the following? • Treatment and control of bleeding episodes • Perioperative management of bleeding • Prevention of bleeding episodes	☐	☐	**Please provide documentation**
ADYNOVATE®, AFSTYLA®, ELOCTATE™ OR ALPROLIX™:			
5. Has the member tried and failed or had an intolerance/contraindication to a shorter acting recombinant factor OR has the physician provided rationale for use of longer acting recombinant factor?	☐	☐	**Please provide documentation**
NOVOSEVEN RT®			
6. Does the member have one of the following FDA-approved indications? • Hemophilia A or B with inhibitors • Acquired hemophilia • Congenital factor VII deficiency • Glanzmann thrombasthenia	☐	☐	**Please provide documentation**
HEMLIBRA®			
7. Does the member have diagnosis of Hemophilia A?	☐	☐	
8. Is the request for routine prophylaxis?	☐	☐	
9. For members with Hemophilia A with inhibitors, are the high titer factor VII inhibitors ≥5 Bethesda units?	☐	☐	**Please provide documentation**
10. For members with Hemophilia A without inhibitors, does the member have one of the following: • Diagnosis of severe Hemophilia A AND documentation of endogenous factor VIII levels <1%, OR • Diagnosis of moderate Hemophilia A AND documentation of endogenous factor levels of 1% to 5%, OR • Diagnosis of mild hemophilia A AND documentation of endogenous factor levels of ≥ 5% AND clinical documentation showing trial and failure of prophylactic factor VIII replacement products, OR • Patient is currently on Hemlibra®, has a diagnosis of Hemophilia A, and not receiving extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla) for treatment of breakthrough bleeding?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member provided the current number of on-hand doses since previous authorization?	☐	☐	**Please provide documentation**
3. For patients using Hemlibra®, has therapy shown to be effective with evidence of a positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 110
Origination Date: 11/12/2020
Reviewed/Revised Date: 11/23/2020
Next Review Date: 11/23/2021
Current Effective Date: 01/01/2021