ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM

(form effective 9/17/2024)

Fax to PerformRx℠ at **1-866-880-3679**, or to speak to a representative call **1-855-839-3883**.

AmeriHealth Caritas New Hampshire | PerformRx℠ Next Generation Pharmacy Benefits

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:
Name of office contact:	Contact's phone number:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:		
Apt #:	City/state/zip:	Phone:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	NPI:
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

Is the medication prescribed by a hematologist: ☐ Yes ☐ No

CLINICAL INFORMATION

Product requested: ☐ Hemlibra	☐ Factor (name):	J-code:	Weight: lbs/kg
Strength/vial size:		# of vials:	NDC#:
Strength/vial size:		# of vials:	NDC#:
Administration date: (to)	(from)	Dispense date:	
DX code (required):		Diagnosis (submit documentation):	
Directions:		Total quantity requested:	Duration:

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
NPI#:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

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

1. For HEMLIBRA (emicizumab), one of the following:
   - ☐ Has a diagnosis of severe hemophilia A and ONE (1) of the following:
   - ☐ Member has tried Factor VIII products and is not well managed due to limited venous access (attestation must be submitted from prescriber)
   - ☐ Request is for routine prophylaxis in patients with a diagnosis of severe hemophilia A WITH Factor VIII inhibitors and history of spontaneous or traumatic bleeding episode
   - ☐ Request is for routine prophylaxis in patients with a diagnosis of severe hemophilia A WITHOUT Factor VIII inhibitors and patient requires management with Factor VIII products at a total weekly dose of >100 U/kg (attestation must be submitted by prescriber)
2. Request is for Hemophilia Factor VIII Replacement Products for Hemophilia A
   - ☐ Has Hemophilia A
3. For a non-preferred medication:
   - ☐ If the request is for any Factor VIII replacement product other than Novoeight, the member has a trial and failure or has a medical reason for utilizing Novoeight, if appropriate based on the member's diagnosis.

RENEWAL REQUESTS

4. Experienced a positive clinical response since starting the requested medication:

☐ Yes _____ ☐ No _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: