OKLAHOMA Health Care Authority

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**State of Oklahoma**
**SoonerCare**

# Alhemo® (concuzumab-mtci) Prior Authorization Form

***Member Name:_____ Date of Birth:_____ Member ID#:_____***

## Drug Information

***Pharmacy Billing (NDC:_____) Start Date (or date of next dose):_____***

***Dose:_____ Regimen:_____***

## Pharmacy Information

***Pharmacy NPI:_____ Pharmacy Name:_____***

***Pharmacy Phone:_____ Pharmacy Fax:_____***

## Prescriber Information

***Prescriber NPI:_____ Prescriber Name:_____***

***Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____***

## Criteria

**For Initial Authorization:**

1. Please indicate the diagnosis and information:
   - ☐ **Hemophilia A or B with inhibitors**
   - ☐ **Other:** _____
2. Please provide member's weight: _____(kg); Date taken: _____
3. Is member undergoing immune tolerance induction? Yes☐ No☐
4. Does member have a history of, or is at high risk for thromboembolic events? Yes☐ No☐
5. For females of reproductive potential;
   a. Is member pregnant? Yes☐ No☐
      i. If yes, or if member becomes pregnant during treatment, will the risk to the fetus be weighed against the benefit to the mother? Yes☐ No☐
   b. Does member agree to use effective birth control during treatment and for at least 7 weeks after the last dose? Yes☐ No☐
6. Is member experiencing repeated breakthrough bleeding episodes despite compliance with current prophylaxis regimen? Yes☐ No☐
   a. If no, please provide a patient-specific, clinically significant reason why current prophylaxis treatment is no longer appropriate: _____
7. Does prescriber agree that member will not be continuing on other prophylactic therapies? Yes☐ No☐
8. Is Alhemo® prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC? Yes☐ No☐
   a. Name of HTC: _____
9. Has member or caregiver been trained on the subcutaneous administration of Alhemo®? Yes☐ No☐



Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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## Criteria

**For Initial Authorization:** *(continued)*

10. Has member been counseled on the potential risk of thrombosis and use of bypassing agents at the lowest possible dose for breakthrough bleeding episodes based on severity and location of bleed? Yes☐ No☐
11. Does prescriber agree to use the following FDA approved dosing regimen as outlined in the package labeling? Yes☐ No☐
    - Day 1: loading dose of 1mg/kg
    - Day 2: 0.2mg/kg once daily until individualization of maintenance dose
    - At week 4, prescriber must measure concizumab plasma concentration for dose optimization
    - After plasma concentration is ascertained and no later than week 8, the dose should be adjusted based on lab results as follows
        - <200ng/ml: 0.25mg/kg daily; or
        - 200-4,000ng/ml: continue 0.2mg/kg daily; or
        - >4,000ng/ml: 0.15mg/kg daily
    - Additional plasma concentration measurements should be done 8 weeks post maintenance dose initiation and regularly thereafter

**Additional Information:** _____

_____

_____

_____

**For Continued Authorization:**

1. Date of last dose: _____
2. Has the member experienced any adverse drug reactions related to Alhemo® therapy? Yes☐ No☐
   *If yes, please specify adverse reactions:* _____
3. Please provide documentation of clinical effectiveness: _____

_____

_____



**Prescriber Signature:** _____ **Date:** _____

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*** *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants Product Based
Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4