OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Hemophilia Non-Factor Products Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Name of Medication: _____ Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

If pharmacy billing, Pharmacist name: _____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Diagnosis (ICD-10): _____ Inhibitor: Yes☐ No☐
2. Is prescriber a hematologist specializing in rare bleeding disorders or practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC? Yes☐ No☐
3. Member's weight: _____(kg); Date taken: _____
4. Does the prescriber attest that the member will not be continuing other prophylactic therapies for Alhemo®, Hemlibra® and Hympavzi®, or longer than 7 days for Qfitlia™? Yes☐ No☐
5. For **Alhemo®**:
   a. Is member undergoing immune tolerance induction? Yes☐ No☐
   b. Does the member have a history of or is at high risk for thromboembolic events? Yes☐ No☐
   c. For females of reproductive potential:
      i. Is member pregnant? Yes☐ No☐
         A. 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☐
      ii. Does the member agree to use effective birth control during treatment and for at least 7 weeks after the last dose? Yes☐ No☐
   d. Has the member or caregiver been trained on the subcutaneous administration and storage of Alhemo®? Yes☐ No☐
   e. Has the 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☐

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)*

6. **For Hemlibra®:**
   a. Will prescriber monitor appropriate blood clotting tests and levels utilizing testing which accounts for the interaction of Hemlibra® and blood factors by following the Medical and Scientific Advisory Council (MASAC) guidance? Yes☐ No☐
   b. Will a treatment plan be developed to address breakthrough bleeds and procedures? Yes☐ No☐
   c. Location where first dose will be given: _____
   d. **For members with an inhibitor to factor VIII:**
      i. Will member be using Feiba® for breakthrough bleeding? Yes☐ No☐
         1. If yes, has member/caregiver been counseled on the risks of using Feiba® while taking Hemlibra®? Yes☐ No☐
      ii. Will member be closely monitored if any bypassing agent is given? Yes☐ No☐
   e. **For members without an inhibitor:**
      i. Does the member have severe hemophilia A or moderate hemophilia A presenting as severe? Yes☐ No☐
      ii. Does prescriber agree to perform routine lab screening for factor VIII inhibitor while using Hemlibra®? Yes☐ No☐
   f. Hemlibra® dose prescribed: _____ Regimen: _____

   NDCs: _____-_____-____ vials per dose: _____ _____-_____-____ vials per dose: _____
   NDCs: _____-_____-____ vials per dose: _____ _____-_____-____ vials per dose: _____

7. **For Hympavzi®:**
   a. Does the member have moderately severe to severe Hemophilia A or Hemophilia B without inhibitors? Yes☐ No☐
   b. Does the member have a current inhibitor or documented history of an inhibitor? Yes☐ No☐
   c. For females of reproductive potential:
      i. Is member pregnant? Yes☐ No☐
      ii. Will member have a negative pregnancy test prior to therapy initiation? Yes☐ No☐
      iii. Is member willing to use effective contraception during and after treatment for at least 2 months after the last dose? Yes☐ No☐
   d. Does member have uncontrolled human immunodeficiency virus (HIV) as shown by CD4+ counts ≤200cells/mm^3? Yes☐ No☐
   e. Has the member or caregiver been trained on the subcutaneous administration and storage of Hympavzi®? Yes☐ No☐

(Hympavzi® continued on next page)

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

Criteria

For Initial Authorization: *(continued)*

7. **For Hympavzi®:** *(continued from Page 2)*
   f. Has the member been counseled on the use of factor replacement therapy at the lowest possible dose for breakthrough bleeding episodes? Yes☐ No☐
   g. Requests for 300mg weekly:
      i. Does the member weigh ≥50kg? Yes☐ No☐
      ii. Has the member had ≥2 spontaneous bleeding episodese which were treated with factor replacement therapy in the last 6 months despite compliance? Yes☐ No☐
      iii. Has the member developed inhibitors? Yes☐ No☐
8. **For Qfitlia™:**
   a. Does the member have severe hemophilia A or B? Yes☐ No☐
   b. Does the member have a history of or is at high risk for thromboembolic events? Yes☐ No☐
   c. Does the member have clinically significant liver disease? Yes☐ No☐
   d. Does the member have active hepatitis C? Yes☐ No☐
   e. Does the member have an acute or chronic hepatitis B infection? Yes☐ No☐
   f. Does member have uncontrolled human immunodeficiency virus (HIV) as shown by CD4+ counts ≤200cells/mm^3 or viral load ≥20 copies/mL? Yes☐ No☐
   g. Does the member have a history of symptomatic gallbladder disease? Yes☐ No☐
      i. If yes, please provide a reason why the member cannot use other available treatments:

      _____
   h. Does prescriber agree to perform and FDA-cleared test for antithrombin activity at weeks 4, 12, 20, and 24 and adjust the dosing as outlined in package labeling? Yes☐ No☐
   i. Does prescriber agree to perform baseline liver tests prior to initiation of fitusiran and monthly for at least 6 months and after any dose increase? Yes☐ No☐
   j. Has the member or caregiver been trained on the subcutaneous administration and counseled on the storage of fitusiran? Yes☐ No☐
   k. Has the member been counseled on the use of factor replacement therapy or bypassing agent as outlined in the prescribing information for breakthrough bleeding episodes? Yes☐ No☐

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

Criteria

For Continued Authorization:

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

   _____

   _____

4. For Hemlibra®, has there been a decrease in the number of spontaneous bleeding episodes since beginning Hemlibra® treatment? Yes☐ No☐

Additional Information: _____

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

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