Neighborhood Health Plan OF RHODE ISLAND™
910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

# Hemophilia Product Prior Authorization Form

Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries and **fax to 1-844-639-7906** or **call 401-427-8200**. All lab results must be faxed in.

**This request form pertains to the following products:**

| | | | | |
|---|---|---|---|---|
| Feiba | Helixate FS | Alphanate | Hemlibra | Wilate |
| Feiba NF | Kogenate FS | Humate-P | BeneFIX | Idelvion |
| NovoSeven RT | Novoeight | AlphaNine SD | Ixinity | Vonvendi |
| Hemofil M | Recombinate | Mononine | Rixubis | Afstyla |
| Koate-DVI | Xyntha | Bebulin | Alprolix | Hemlibra |
| Monoclate-P | Adynovate | Kovaltry | Coagadex | Jivi |
| Nuwiq | Eloctate | Profilnine | Corifact | |
| Advate | Obizur | Rebinyn | Tretten | |

## I. Demographic Information

| **Patient Information** | | |
|---|---|---|
| First Name | Last Name | Patient Gender |
| Patient DOB | Patient Phone # | Alternative Phone # |
| Patient Address: | | |
| City | State | Zip code |
| **Provider Information** | | |
| Prescriber Name | Contact Name | Contact Phone # |
| NPI | Fax # | |
| Prescriber Address: | | |
| City | State | Zip code |

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| Rendering Provider (Dispensing Pharmacy) Information | | |
|---|---|---|
| Pharmacy Name | NPI | NABP |
| Contact Name | Phone # | Fax # |

| Insurance Information | |
|---|---|
| Policy Holder Name | ID# of Insurance Card |
| Name of Insurance Company | Group # |

**Primary Diagnosis**

- ☐ Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- ☐ Acquired Hemophilia A (Acquired Factor VIII Deficiency)
- ☐ Hemophilia B (Congenital Factor IX Deficiency)
- ☐ von Willebrand Disease
- ☐ Congenital Factor XIII Deficiency
- ☐ Congenital Factor XIII A-subunit Deficiency
- ☐ Hereditary Factor X Deficiency
- ☐ Congenital Factor VII Deficiency
- ☐ Glanzmann's Thrombasthenia

ICD 10 Code

| Patient Inventory (Medication on Hand) | | |
|---|---|---|
| Total Number of Doses on Hand | Total Units on Hand (IU) | Date Verified |

| Clinical Information |
|---|
| Name of Treating Facility |

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| | |
|---|---|
| Treatment status<br>☐ Treatment-naïve<br>☐ Treatment-experienced | Product Name |

Was the patient on a different factor product previously?

☐ Yes
☐ No

If yes, which product and reason for product switching:_____

_____

| | | |
|---|---|---|
| Member's Height | Member's Weight | Severity of Disease<br>☐ Mild (6% to 25% factor level)<br>☐ Moderate (1% to 5% factor level)<br>☐ Severe (< 1% factor level) |
| Dose (IU) | Number of Doses Requested | Total Dose Requested (IU) |

| | |
|---|---|
| Dosing Instructions | Retrospective request?<br>☐ Yes<br>☐ No |
| Type of Use (Check all that applies)<br>☐ Episodic<br>☐ Prophylaxis<br>☐ Acute Bleeding Episode<br>☐ Dental Procedure<br>Date of Procedure:_____<br>☐ Surgical Prophylaxis<br>Date of Procedure:_____ | Place of Administration:<br>☐ Home infusion<br>☐ Outpatient Hemophilia Treatment Center (HTC)<br>☐ Outpatient Hospital<br>☐ Provider's office<br>☐ Self-administration |

Number and Location of bleeds in the past 12 months:

Does the patient have a diagnosis confirmed by blood coagulation testing?

☐ Yes
☐ No

Please provide the following information regarding factor levels

- ☐ Factor VIII for Hemophilia A
- ☐ Factor IX for Hemophilia B
- ☐ Factor X for Hereditary Factor X Deficiency
- ☐ Factor XIII for Congenital Factor XIII or Factor XXIII A-subunit Deficiencies
- ☐ VW Factor for von Willebrand Disease

a. Baseline Factor Level _____

b. Date of Factor Level_____

c. Desired (Target) Factor Level_____

Does the patient have inhibitors to factor products?

- ☐ Yes
- ☐ No

If so, are documentations of inhibitor tests attached? (e.g., Bethesda inhibitor assay)

- ☐ Yes
- ☐ No

Has the patient previously received Immune Tolerance Induction (ITI)?

- ☐ Yes
- ☐ No

If yes, date and duration of the trial and patient response: _____

_____

Did the patient experience at least two documented episodes of spontaneous bleeding into the joints?

- ☐ Yes
- ☐ No

For minimally treated patients (< 50 exposure days to factor products) previously receiving a different factor product, how often will inhibitor testing be performed?

_____

Was a pharmacokinetics (PK) test performed for this patient?

- ☐ Yes
- ☐ No

If so, are PK testing results attached?

- ☐ Yes
- ☐ No

If patient has a diagnosis of Glanzmann's Thrombasthenia, has the patient tried platelet transfusions?

- ☐ Yes
- ☐ No

If yes, date of the trial and patient response: _____

If the patient has a diagnosis of von Willebrand Disease (VWD), has the patient tried desmopressin?

- ☐ Yes
- ☐ No

If no, is the patient contraindicated to desmopressin?

- ☐ Yes
- ☐ No

If yes, what is the reason for contraindication:_____

**For acute bleeding episodes, please provide the following additional information:**

| Location of Bleed | Type of Bleed | Start Date of Bleed: | End Date of Bleed: |
|---|---|---|---|
| | ☐ Minor<br>☐ Moderate<br>☐ Major | | |

| Number of Doses Used | Dose (IU) | Total Amount Used (IU) |
|---|---|---|
| | | |