

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					



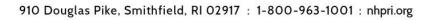


Rendering Provider (Dispensing Pharmacy) Information								
Pharmacy Name				NPI			NABP	
Contact Name Phone #			Fax#			#		
Insurance Information								
Policy Holder Name			ID# of Insurance Card					
Name of Insurance Company				Group #				
Primary Diagnosis								
 □ Congenital Hemophilia A (Congenital 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		d (IU) Date Ve		erified				
Clinical Information								
Name of Treating Facility								



910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

Treatment status Treatment-naïve 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 Mild (6% to 25% factor level) Moderate (1% to 5% factor level) level) Severe (< 1% factor level)		
Dose (IU) Number of Doses R			ested	Total Dose Requested (IU)	
Dosing Instructions		Retrospective request? ☐ Yes ☐ No			
Type of Use (Check all that applies) □ Episodic □ Prophylaxis □ Acute Bleeding Episode □ Dental Procedure □ Date of Procedure: □ Surgical Prophylaxis □ Date of Procedure:		-	Place of Administration: Home infusion Outpatient Hemophilia Treatment Center (HTC) Outpatient Hospital Provider's office 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					
a Desired (Target) Factor Lovel					
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)?					
That the patient previously received infiniture rolerance madellon (111):					
☐ Yes					
□ No					
If yes, date and duration of the trial and patient response:					
if yes, date and duration of the that 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?					
F 11114 F 11114					





Was a pharmacokinetics (PK) test performed for this patient?					
☐ Yes ☐ No					
If so, are PK testing resul	ts attached?				
☐ Yes ☐ No					
If patient has a diagnosis	of Glanzman	nn's Thrombast	henia, has the p	atient tried	platelet transfusions?
☐ Yes ☐ No					
If yes, date of the tria	l 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 Minor Moderate Major		Start Date of Bleed:		End Date of Bleed:
Number of Doses Used Dose (IU)			Total Amo	unt Used (IU)	