HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
HEMOPHILIA AND BLOOD PRODUCTS

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

HEMOPHILIA A AGENTS

☐ Advate® (antihemophilic factor (recombinant), ☐ Alphanate® (antihemophilic factor (human), ☐ Desmopressin (DDAVP), ☐ Helixate FS® (antihemophilic factor (recombinant), ☐ Hemlibra® (emicizumab), ☐ Hemofil M® (antihemophilic factor (human), ☐ Humate-P® (antihemophilic factor (human), ☐ Koate-DVI® (antihemophilic factor (human), ☐ Kogenate FS® (antihemophilic factor (recombinant), ☐ Kovaltry® (antihemophilic factor (recombinant), ☐ Monoclate-P® (antihemophilic factor (human), ☐ Novoeight® (antihemophilic factor (recombinant), ☐ Novoseven RT® (coagulation factor VIIa (recombinant), ☐ Obizur (antihemophilic factor (recombinant), ☐ Recombinate® (antihemophilic factor (recombinant), ☐ Sevenfact® (coagulation factor VIIa (recombinant)-jncw) ☐ Wilate® (antihemophilic factor (human), ☐ Xyntha® (antihemophilic factor (recombinant)
Long-Acting Products: ☐ Adynovate® (antihemophilic factor (recombinant), ☐ Afstyla® (antihemophilic factor (recombinant), ☐ Alhemo® (concizumab-mtci), ☐ Altuviiio® (antihemophilic factor [recombinant]), ☐ Eloctate™(antihemophilic factor (recombinant), ☐ Hympavzi™ (marstacimab-hncq),

HEMOPHILIA B AGENTS

☐ Alphanine SD® (coagulation Factor IX), ☐ Benefix® (coagulation factor IX (recombinant), ☐Mononine® (coagulation Factor IX), ☐ Ixinity® (coagulation factor IX (recombinant), ☐ Profilnine® (factor IX complex), ☐ Rixubis® (coagulation factor IX (recombinant)), ☐ Sevenfact® (coagulation factor VIIa (recombinant)-jncw)
Long-Acting Products: ☐ Alhemo® (concizumab-mtci), ☐ Alprolix™ (coagulation factor IX (recombinant)), ☐ Hympavzi™ (marstacimab-hncq)

VON WILLEBRAND DISEASE (VWD) AGENTS

☐ Alphanate® (antihemophilic factor (human), ☐ Stimate® (Desmopressin (DDAVP), ☐ Humate-P® (antihemophilic factor (human), ☐ Wilate (coagulation factor VIII complex (human)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review?	☐	☐	

By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.			
2. Does the member have a diagnosis of moderate or severe hemophilia A, hemophilia B, or laboratory confirmed diagnosis of type 2B or type 3 Von Willebrand's disease?	☐	☐	**Please provide documentation**
3. For members with mild hemophilia A OR type 1, 2A, 2M, or 2N Von Willebrand Disease, has the member tried and failed, or has a contraindication/intolerance, or a clinical reason for not using desmopressin (DDAVP)?	☐	☐	**Please provide documentation**
4. Is the request made by, or in consultation with, a hematologist?	☐	☐	
5. Will the request be made for one of the following? • Treatment and control of bleeding episodes • Perioperative management of bleeding • Prevention of bleeding episodes	☐	☐	**Please provide documentation**
ADYNOVATE®, AFSTYLA®, ELOCTATE™ OR ALPROLIX™:			
1. Has the member tried and failed or had an intolerance/contraindication to a shorter acting recombinant factor OR has the physician provided rationale for use of longer acting recombinant factor?	☐	☐	**Please provide documentation**
NOVO-SEVEN RT®			
1. Does the member have one of the following FDA-approved indications? • Hemophilia A or B with inhibitors • Acquired hemophilia • Congenital factor VII deficiency • Glanzmann thrombasthenia	☐	☐	**Please provide documentation**
HEMLIBRA®			
1. Does the member have diagnosis of Hemophilia A?	☐	☐	
2. Is the request for routine prophylaxis or reducing frequency of bleeding episodes?	☐	☐	
3. Will it be used in combination with Immune Tolerance Induction (ITI)?	☐	☐	
4. Does the member have at least 2 documented episodes of spontaneous bleeding into joints?	☐	☐	**Please provide documentation**
5. For members with Hemophilia A with inhibitors, are the high titer factor VII inhibitors ≥5 Bethesda units?	☐	☐	**Please provide documentation**
6. For members with Hemophilia A without inhibitors, does the member have one of the following: • Diagnosis of severe Hemophilia A AND documentation of endogenous factor VIII levels <1%, OR • Diagnosis of moderate Hemophilia A AND documentation of endogenous factor levels of 1% to 5%, OR • Diagnosis of mild hemophilia A AND documentation of endogenous factor levels of ≥ 5%	☐	☐	**Please provide documentation**
7. Has the member tried and failed, or have documented contraindications, to two prophylactic factor VIII replacement products?	☐	☐	**Please provide documentation**
8. Is the member is currently on Hemlibra AND diagnosed with Hemophilia A AND not receiving any extended half-life factor			**Please provide documentation**

VIII replacement products (Elotctate, Adynovate, Afstyla, Jivi) for treatment of breakthrough bleeding?			
SEVENFACT®			
1. Does the member have one of the following FDA-approved indications? • Hemophilia A or B with inhibitors	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member provided the current number of on-hand doses since previous authorization?	☐	☐	**Please provide documentation**
3. For patients using Hemlibra®, has therapy shown to be effective with evidence of a positive clinical response?	☐	☐	**Please provide documentation**
4. Does documentation demonstrate medical necessity which may include, but is not limited to, documentation of bleeding episodes?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-110
Origination Date: 07/01/2024
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
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