

Factor Replacement Products Prior Authorization Form

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

Pharmacy Information

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

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

Fill Date: _____

Prescriber Information

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

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

Clinical Information

1. Diagnosis (ICD-10): _____ Inhibitor: Yes ___ No ___

2. Factor Replacement Product: _____

3. NDCs to potentially be used throughout the year (to be completed by the dispensing pharmacy):

_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____
_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____
_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____

4. Estimated total units to be used per year: _____

5. For members requesting Feiba[®], NovoSeven RT[®], or Sevenfact[®]:

a. For a diagnosis of hemophilia A with an inhibitor, a patient-specific, clinically significant reason why the member cannot use Alhemo[®], Hemlibra[®], or Qfitlia[™] for prophylaxis therapy: _____

b. For a diagnosis of hemophilia B with an inhibitor, a patient-specific, clinically significant reason why the member cannot use Alhemo[®] or Qfitlia[™] for prophylaxis therapy: _____

6. For members requesting an extended half-life factor product:

a. For a diagnosis of hemophilia A, a patient-specific, clinically significant reason why the member cannot use Advate[®], Altuviio[®], Jivi[®], or current factor VIII replacement product: _____

b. For a diagnosis of hemophilia B, a patient-specific, clinically significant reason why the member cannot use Benefix[®], Alprolix[®], Idelvion[®], Rebinyn[®], or current factor IX replacement product: _____

(Page 1 of 2)

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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7. For extended half-life products, Coagadex, Corifact, and Obizur requests: Has a half-life study been performed? Yes ___ No ___ Date(s) performed: _____
8. For extended half-life factor products, was there a significant benefit seen in half-life? Yes ___ No ___
- I recommend this patient be followed by an OHCA Care Management Nurse.

Additional Information: _____

(Page 2 of 2)

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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Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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