GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Hemlibra® Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed.
Please complete one form per member.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Diagnosis:

❑ Hemophilia A (congenital factor VIII deficiency) **with** factor VIII inhibitors
❑ Hemophilia A (congenital factor VIII deficiency) **without** factor VIII inhibitors **(answering Q11 is mandatory)**
❑ Other (ICD-10 Code(s), plus description):_____

For All Requests:

1. Select where the requested medication will be administered:
   ❑ Patient's Home ❑ Long-term care facility ❑ Clinic or physician's office
2. What is the patient's weight? _____ (kg)
3. Is the patient currently treated with the requested agent? ❑ **Yes** ❑ **No**
   If **yes**, when was treatment with the requested dose started? _____
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., prescriber working in hemophilia treatment center, hematologist with hemophilia experience)? ❑ **Yes** ❑ **No**
   If **no**, has the prescriber consulted with a specialist? ❑ **Yes** ❑ **No**
5. Is the requested agent prescribed for prophylactic use? ❑ **Yes** ❑ **No**
6. Is the patient currently using a Factor VIII product (e.g., Advate, Adynovate, Eloctate, Nuwiq, Recombinate, Xyntha) or a bypassing agent (e.g., Feiba, NovoSeven) for prophylaxis treatment? ❑ **Yes** ❑ **No**
   If **yes**, which Factor VIII product is the patient is currently on? _____
   If **yes**, will the prophylaxis treatment be discontinued? ❑ **Yes** ❑ **No**
   Please indicate the current dose of factor VIII product being used:
   - ❑ Prophylactic Dosing _____
   - ❑ On-demand dosing for mild bleeds _____
   - ❑ On-demand dosing for moderate bleeds _____
   - ❑ On-demand dosing for severe bleeds _____
   - ❑ Other: _____
7. Please select the patient's Hemophilia A Severity Level: ❑ **Mild** ❑ **Moderate** ❑ **Severe**
   Please provide the patient's inhibitor level: _____Bethesda Units (BU) **Or** ❑ Not applicable (N/A)
8. Has the patient tried and had an inadequate response to Immune Tolerance Therapy (ITT) also known as Immune Tolerance Induction (ITI)? ❑ **Yes** ❑ **No**

<Please continue on page 2>

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9. Is the patient currently using a bypassing agent (e.g., Feiba, NovoSeven)? ❑ **Yes** ❑ **No**

   If **yes**, please indicate the type of treatment the bypassing agent is being used for:

   ❑ Prophylactic Dosing _____ ❑ On-demand dosing for bleeds _____

   ❑ Other: _____

   If **yes**, did the patient have an inadequate response to treatment or is the patient's condition not adequately controlled by treatment with the bypassing agent? ❑ **Yes** ❑ **No**

   If **yes**, is the patient using more than 5 doses per week of the bypassing agent? ❑ **Yes** ❑ **No**

   If **yes**, will the bypassing agent be discontinued before starting treatment with the requested medication? ❑ **Yes** ❑ **No**

10. Will the patient be receiving Feiba [activated prothrombin complex concentrate (aPCC)] for breakthrough bleeds? ❑ **Yes** ❑ **No**

    If **yes**, will the patient be monitored for thrombotic microangiopathy and thromboembolism? ❑ **Yes** ❑ **No**

    If **yes**, has the prescriber counseled the patient on the maximum dose to be used (i.e., no more than 100 units/kg/24 hours)? ❑ **Yes** ❑ **No**

11. Please list all reasons for selecting the requested medication, strength, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose has been tried). If Hemlibra is being requested for use ***without*** the presence of inhibitors, please provide rationale for use:

    _____

    _____

    _____

    _____

12. Please list all other medications the patient is currently taking for treatment of this diagnosis:

    _____

    _____

13. Please list all medications the patient has previously tried and failed for treatment of this diagnosis.

    _____ Date(s): _____ _____ Date(s): _____

    _____ Date(s): _____ _____ Date(s): _____

    _____ Date(s): _____ _____ Date(s): _____

For Renewal Requests:

14. Has the patient shown clinical benefit* since starting the requested agent (i.e., less breakthrough bleeds)? ❑ **Yes** ❑ **No**

    ***Please note, a copy of the patient's treatment log must be provided.**

15. Is the patient receiving Feiba [activated prothrombin complex concentrate (aPCC)] for breakthrough bleeds? ❑ **Yes** ❑ **No**

    If **yes**, will the patient be monitored for thrombotic microangiopathy and thromboembolism? ❑ **Yes** ❑ **No**

I attest that this information is accurate and true and that documentation supporting this information is available for review if requested by the Department of Community Health.

Physician Signature: _____

Contact Person: _____ Phone: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-877-239-4565.