ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM

(form effective 7/7/2021)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:
Name of office contact:	Contact's phone number:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:		
Apt #: / City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	NPI:
Street address:		
Suite #: / City/state/zip:		
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: ☐ Hemlibra	☐ Factor (name):	J-code:	Weight: lbs/kg
Strength/vial size:		# of vials:	NDC#:
Strength/vial size:		# of vials:	NDC#:
Administration date: (to)	(from)	Dispense date:	
DX code (required):		Diagnosis (submit documentation):	
Directions:		Total quantity requested:	Duration:

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
NPI#:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS (Complete the section(s) below applicable to the patient and this request and SUBMIT DOCUMENTATION for each item.)

1. For HEMLIBRA (emicizumab):
   - ☐ Has a diagnosis of severe hemophilia A AND
   - ☐ Failed to achieve clinical goals with or has a contraindication or intolerance to routine FVIII replacement prophylaxis
   - ☐ Has been using Hemlibra in the past 90 days
   - ☐ Has a diagnosis of severe hemophilia A with inhibitors

2. For a BYPASSING AGENT (e.g., FEIBA NF, Novoseven):
   For routine prophylaxis:
   - ☐ Has hemophilia A with inhibitors AND (check all that apply):
   - ☐ Failed to achieve clinical goals with Hemlibra
   - ☐ Has a medical reason why Hemlibra cannot be used
   - ☐ Has been using the requested bypassing agent for routine prophylaxis within the past 90 days
   - ☐ Has hemophilia B with inhibitors

   For use other than routine prophylaxis (e.g., episodic/on-demand treatment, intermittent/periodic prophylaxis):
   - ☐ Has hemophilia A with inhibitors OR has hemophilia B with inhibitors

3. For a non-preferred FACTOR VIII, FACTOR IX, or VWF:
   - ☐ Has been using the requested product within the past 90 days AND has a medical reason to continue using the requested product
   - ☐ Failed to achieve clinical goals with or has a contraindication or intolerance to the preferred FVIII, FIX, or FVIII/VWF products

   Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

RENEWAL REQUESTS

4. Experienced a positive clinical response since starting the requested medication: ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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