Send To: ❑ AcariaHealth
❑ Specialty Pharmacy Provider:_____

Phone: 800-218-7453 x22080
Fax: 866-683-5631

Prior Authorization Form
Antihemophilia

Date: _____ Date Medication Required:_____

superior healthplan

Patient Name: _____	Physician Name: _____
Address: _____	State Lic #_____ DEA # _____
City: _____ State: _____ Zip:_____	NPI # _____ UPIN# _____
Home Phone: (_____) _____ - _____	Practice Name/Hospital: _____
Alt Phone: (_____) _____ - _____	Specialty: _____
Cell Phone: (_____) _____ - _____	Address: _____
Date of Birth: _____/_____/_____ Sex: ❑ Male ❑Female	City: _____ State: _____ Zip: _____
Patient Soc. Sec #: XXX-XX-_____	Physician's Phone: (_____) _____ - _____
Allergies:_____	Physician's Fax: (_____) _____ - _____
County: _____ Weight _____ ❑lbs ❑kg Height: _____	Nurse/Key Office Contact: _____ Direct Ext: _____

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card:	Name of Insurer: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____
Primary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____		Tel #: _____
Secondary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____		Tel #: _____

DIAGNOSIS *(Required)*

❑ Factor VII deficiency ❑ von Willebrand disease (vWD) ❑ Acquired hemophilia ❑ Acquired inhibitors to Factor VIII or Factor XI or XII
❑ Hemophilia with inhibitors ❑ Hemophilia A ❑ Hemophilia B ❑ Other: _____

What is the ICD 9 / ICD 10 code? _____

PATIENT EVALUATION

1. Is the prescription ordered by or under consultation of a hematologist? ❑Yes ❑No
2. Has the patient received hepatitis A vaccine? ❑ Yes ❑ No
3. Has the patient received hepatitis B vaccine? ❑ Yes ❑ No
4. If at risk, will the patient be monitored for signs and symptoms of thrombosis? ❑Yes ❑ No
5. Has the patient demonstrated a hypersensitivity to Factor or any of its components (e.g., mouse, hamster, bovine proteins)? ❑ Yes ❑ No
6. Provide most recent assay level attached to the prior authorization request: Date_____ Assay Type _____ Level_____

Complete the appropriate Section and Group below as applicable to the patient's prescribed therapy and diagnosis (Sections A-E)

SECTION A: NovoSeven or NovoSeven RT

Group 1: Diagnosis Factor VII deficiency

7. Will the NovoSeven product be used for prevention or control of bleeding episodes? ❑ Yes ❑ No

Group 2: Hemophilia with inhibitors

8. What is Bethesda titer (BU) level? _____BU
9. Has the patient received prior treatment with Factor VIII? ❑ Yes ❑ No
10. Has the patient had an inadequate response to Factor VIII dose increases of 20 units/Kg/BU? ❑ Yes ❑ No

SECTION B: Feiba VH or Feiba NF or Autoplex T

11. Does the patient have inhibitors? ❑ Yes ❑ No
12. Does the patient have significant signs of disseminated intravascular coagulation (DIC)? ❑ Yes ❑ No
13. If Feiba,, will Feiba be administered at a high dose (e.g. 100 units/kg as a single dose or 200 units/kg as a daily dose)? ❑ Yes ❑ No *If No, Skip to #15
14. If Feiba, will the high dose be given only as long as necessary to stop the bleeding? ❑ Yes ❑ No
15. Document Bethesda titer (BU): _____BU
16. Does the patient have other thrombotic risk factors? ❑ Yes ❑ No

SECTION C: Advate, Alphanate, Helixate FS, Hemofil-M, Humate-P, Koate-DVI, Kogenate FS, Monarc-M, Monoclate-P, Recombinate, Refacto, Wilate, Xyntha

17. Has the patient tried and failed desmopressin? ❑ Yes ❑ No *If No, Skip to # 20

Please continue to second page

Member Name: _____ DOB: _____

18. Did the patient inadequately respond to desmopressin (e.g., inability to provide adequate level of factor)? ❑ Yes ❑ No

19. Is the patient intolerant or contraindicated to desmopressin therapy? ❑ Yes ❑No

20. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No *If No, Skip to Dx Group

21. Document clinical reason: _____

Group 1: Hemophilia A

22. What is Factor VIII assay level (% activity)?
❑Mild (greater than 5%) ❑ Moderate to severe (less than 1% to 5%) ❑ No Factor VIII assay level

23. Will Factor VIII be used for control of spontaneous and trauma-induced hemorrhagic episodes? ❑ Yes ❑ No

24. Will Factor VIII be used for surgical prophylaxis? ❑ Yes , document surgical procedure _____ ❑ No

25. Does the patient have severe hemophilia A with less than or equal to 1% of normal factor (less than or equal to 0.01 IU/ml)? ❑ Yes ❑ No

26. Does the patient have history of 2 or more episodes of spontaneous bleeding into joints? ❑Yes ❑ No

27. Does the patient have an inhibitor? ❑Yes ❑ No * If yes please fill out #28 and #29

28. What is Bethesda titer (BU) level? _____BU

29. Will Factor VIII be used for immune tolerance induction? ❑Yes ❑ No

Group 2: von Willebrand disease (vWD)

30. Does the patient have spontaneous,trauma-induced bleeding episodes? ❑ Yes ❑ No

31. Will blood factor product be used to prevent excessive bleeding during and after surgery? ❑ Yes ❑ No

32. Does the patient have history of 2 or more spontaneous bleeding episodes into the joints? ❑ Yes ❑ No

33. What is the vWD type?
❑Type 1 ❑ Type 2A ❑ Type 2B ❑ Type 2M ❑ Type 2N ❑ Type 3

SECTION D: AlphaNine SD, BeneFIX, Bebulin, Bebulin VH, Mononine, Profilnine SD, Proplex

34. Does the patient have signs of fibrinolysis or does the patient have significant signs of disseminated intravascular coagulation (DIC)? ❑ Yes ❑ No

35. Will Factor IX be used for control of spontaneous and trauma-induced hemorrhagic episodes? ❑ Yes ❑ No

36. Will Factor IX be used for surgical prophylaxis? ❑ Yes , document surgical procedure _____ ❑ No

37. Does the patient have history of 2 or more spontaneous bleeding episodes into the joints? ❑ Yes ❑ No

38. Does the patient have an inhibitor? ❑Yes ❑ No * If yes please fill out #39 and #40

39. What is Bethesda titer (BU) level? _____BU

40. Will Factor VIII be used for immune tolerance induction? ❑Yes ❑ No

SECTION E: Corifact

41. Has diagnosis been confirmed with specific factor XIII assays? ❑Yes ❑ No

42. Will Corifact be used for surgical prophylaxis? ❑ Yes , document surgical procedure _____ ❑ No

****NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You****

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: _____ **Date**____/_____/_____