



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Hemophilia

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

- What drug is being prescribed?
 Advate Alphanate AlphaNine SD Bebulin BeneFIX Feiba NF Feiba VH
 Helixate FS Hemofil M Humate P Koate Kogenate Monarc-M Monoclate-P
 Mononine NovoSeven RT Profilnine Recombinate ReFact Wilate Xyntha
 Other _____
- What is the diagnosis?
 Factor VII deficiency von Willebrand disease (vWD)
 Hemophilia with inhibitors Acquired inhibitors to Factor VIII or Factor XI or XII
 Acquired hemophilia Central diabetes insipidus
 Hemophilia A Temporary polyuria/polydypsia
 Hemophilia B Other _____
- What is the ICD9?** _____
- Is the prescription ordered by or under consultation of a hematologist? Yes No
- Has the patient received hepatitis A vaccine? Yes No
- Has the patient received hepatitis B vaccine? Yes No
- If at risk, will the patient be monitored for signs and symptoms of thrombosis? Yes No

Complete the applicable Section and Group below designated for the patient's prescribed therapy and diagnosis (Sections A-E)

SECTION A: NovoSeven

- Has the patient demonstrated a hypersensitivity to NovoSeven RT or any of its components (e.g., mouse, hamster or bovine proteins)? Yes No

Group 1: Diagnosis Factor VII deficiency

- Will NovoSeven RT be used for prevention or control of bleeding episodes? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

Group 2: Hemophilia with inhibitors

10. What is Bethesda titer (BU) level? _____ BU
11. Has the patient received prior treatment with Factor VIII? Yes No
12. 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

13. Does the patient have inhibitors? Yes No
14. Does the patient have significant signs of disseminated intravascular coagulation (DIC)?
 Yes No
15. 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 #17*
16. Will the high dose be given only as long as necessary to stop the bleeding? Yes No
17. Document Bethesda titer (BU): _____ BU
18. Does the patient have other thrombotic risk factors? Yes No

SECTION C: DDAVP injection or Stimate nasal spray

19. Does the patient have hyponatremia or a history of uncorrected hyponatremia? Yes No

Group 1: Central diabetes insipidus

20. Does the patient have moderate to severe renal impairment (CrCl less than 50 mL/min)?
 Yes No

Group 2: Hemophilia A and von Willebrand disease (vWD)

21. What is Factor VIII level? _____ %
22. If diagnosis is von Willebrand disease (vWD), what is the **type** of vWD?
 Type 1 Type 2A Type 2B Type 2M Type 2N Type 3

SECTION D: Advate, Alphanate, Helixate FS, Humate-P, Koate-DVI, Kogenate FS, Recombinate, Wilate, Xyntha

23. Has the patient tried and failed desmopressin? Yes No **If No, Skip to # 25*
24. Did the patient inadequately respond to desmopressin? Yes No
25. Is the patient intolerant or contraindicated to desmopressin therapy? Yes No
26. Is there a clinical reason for not trying desmopressin first? Yes No **If No, Skip to Dx Group*
27. Document clinical reason: _____

Group 1: Hemophilia A

28. Has the patient demonstrated a hypersensitivity to Factor VIII or any of its components (e.g., mouse, hamster, bovine proteins)? Yes No
29. What is Factor VIII assay level (% activity)?
 Mild (greater than 5%) Moderate to severe (less than 1% to 5%) No Factor VIII assay level

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Patient Name: _____ **Patients Date of Birth:** _____
Patients ID : _____

30. Has desmopressin failed to provide adequate levels of Factor VIII activity or is the patient unable to tolerate it? Yes No
31. Will Factor VIII be used for control of spontaneous and trauma-induced hemorrhagic episodes?
 Yes No
32. Will Factor VIII be used for surgical prophylaxis? Yes No
33. 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
34. Does the patient have history of 2 or more episodes of spontaneous bleeding into joints?
 Yes No

Group 2: von Willebrand disease (vWD)

35. Does the patient have spontaneous, trauma-induced bleeding episodes? Yes No
36. Will blood factor product be used to prevent excessive bleeding during and after surgery?
 Yes No
37. Does the patient have history of 2 or more spontaneous bleeding episodes into the joints?
 Yes No
38. What is the vWD type?
 Type 1 Type 2A Type 2B Type 2M Type 2N Type 3

SECTION E: AlphaNine SD, BeneFIX, Bebulin VH, Mononine, Profilnine SD

39. Has the patient demonstrated a hypersensitivity to Factor IX or any of its components (e.g., hamster, mouse proteins)? Yes No
40. Will Factor IX be used for control of spontaneous and trauma-induced hemorrhagic episodes?
 Yes No
41. Will Factor IX be used for surgical prophylaxis? Yes No
42. Does the patient have history of 2 or more spontaneous bleeding episodes into the joints?
 Yes No

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

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