Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Hemophilia Agents

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The member is prescribed the hemophilia agent for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q2. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The requested drug is being prescribed by or in consultation with a hematologist or hemophilia treatment center practitioner.

☐ Yes ☐ No

Q4. Is this a reauthorization request? If YES, go to 11. If NO, go to 5.

☐ Yes ☐ No

Q5. Is the request for Hemlibra? If YES, go to 6. If NO, go to 9.

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☐ Yes ☐ No

Q6. For Hemlibra, one of the following:
i. Has a diagnosis of congenital hemophilia A with inhibitors,
ii. Has a diagnosis of severe congenital hemophilia A,
iii. Has a diagnosis of congenital hemophilia A and a history of at least 1 spontaneous episode of bleeding into a joint or other serious bleeding event
If YES, go to 7.

☐ Yes ☐ No

Q7. Hemlibra will not be used in conjunction with other non-factor products used for routine prophylaxis in hemophilia A and B (i.e., Alhemo, Hympavzi, Qfitlia). If YES, go to 8.

☐ Yes ☐ No

Q8. Prophylactic use of bypassing agents and factor VIII agents will be discontinued (note: use of these agents is permitted for breakthrough bleeding).

☐ Yes ☐ No

Q9. For a bypassing agent (i.e., FEIBA, NovoSeven RT, Sevenfact), has a diagnosis of hemophilia A or B with inhibitors documented by inhibitor titer greater than or equal to 5 Bethesda units per milliliter (BU/mL) or a history of an inhibitor titer greater than or equal to 5 BU/mL.

☐ Yes ☐ No

Q10. Has a diagnosis of one of the following (depending on product requested and compendial uses):
i. Acquired hemophilia
ii. Congenital factor VII deficiency
iii. Glanzmann's thrombasthenia
iv. Acquired von Willebrand syndrome
v. Inhibitors to factor IX

☐ Yes ☐ No

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Q11. For reauthorization, the member demonstrates a beneficial clinical response to therapy, as evidenced by ANY of the following:
a. Reduction in frequency or severity of bleeding events
b. Reduction in the number of bleeding events that required treatment
c. Reduction in the number of spontaneous bleeds
If YES, go to 12.

☐ Yes ☐ No

Q12. Is the request for Hemlibra? If YES, go to 13.

☐ Yes ☐ No

Q13. For Hemlibra, prophylactic use of bypassing agents or factor VIII agents will not occur while receiving Hemlibra (note: use of these agents is permitted for breakthrough bleeding).

☐ Yes ☐ No

Q14. Additional Information:

Prescriber Signature

Date

v2025