HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antihemophilia Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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 Antihemophilia 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 member is prescribed the Antihemophilia Agent by a hematologist or hemophilia treatment center practitioner.

☐ Yes ☐ No

Q4. The member does not have a contraindication to the requested drug.

☐ Yes ☐ No

Q5. The request is for continuation for the Antihemophilia Agent. If YES, go to 6. If NO, go to 7.

☐ Yes ☐ No

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Q6. The member has documentation of a positive clinical response to the requested Antihemophilia Agent.

☐ Yes ☐ No

Q7. The request is for a bypassing agent (e.g., FEIBA, NovoSeven RT, Sevenfact). If YES, go to 8. If NO, go to 12.

☐ Yes ☐ No

Q8. The member has a diagnosis of hemophilia A with inhibitors. If YES, go to 9. If NO, go to 11.

☐ Yes ☐ No

Q9. The member is using the requested drug for routine prophylaxis and meets ONE of the following:

☐ Has documentation of failure to achieve clinical goals with emicizumab,
☐ Has documentation from the prescriber of a medical reason why emicizumab cannot be used,
☐ Has a current history (within the past 90 days) of being prescribed the same bypassing agent for routine prophylaxis.

Q10. The member is using the requested drug for episodic/on-demand treatment or intermittent/periodic prophylaxis.

☐ Yes ☐ No

Q11. The member has a diagnosis of one of the following:

☐ Hemophilia B with inhibitors,
☐ Acquired hemophilia,
☐ Congenital factor VII deficiency,
☐ Glanzmann's thrombasthenia;

Q12. The request is for a non-preferred extended half-life factor VIII replacement agent. If YES, go to 13. If NO, go to 15.

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☐ Yes ☐ No

Q13. The member has documentation of failure to achieve clinical goals OR a contraindication or an intolerance to the preferred extended half-life factor VIII replacement agent(s) approved or medically accepted for the beneficiary's diagnosis or indication.

☐ Yes ☐ No

Q14. The member meets both of the following:

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred extended half-life factor VIII replacement agent

☐ . Has documentation from the prescriber of a medical reason why the beneficiary should continue to use the non-preferred extended half-life factor VIII replacement agent (e.g., has a history of inhibitors and has not developed inhibitors while using the requested non-preferred agent)
See the Preferred Drug List (PDL) for the list of preferred Antihemophilia Agents at: https://papdl.com/preferred-drug-list.

Q15. The request is for a non-preferred extended half-life factor IX replacement agent. If YES, go to 16. If NO, go to 18.

☐ Yes ☐ No

Q16. The member has documentation of failure to achieve clinical goals OR a contraindication or an intolerance to the preferred extended half-life factor IX replacement agent(s) approved or medically accepted for the beneficiary's diagnosis or indication.

☐ Yes ☐ No

Q17. The member meets both of the following:

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred extended half-life factor IX replacement agent

☐ Has documentation from the prescriber of a medical reason why the beneficiary should continue to use the non-preferred extended half-life factor IX replacement agent (e.g., has a history of inhibitors and has not developed

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Member Name:	Prescriber Name:

	inhibitors while using the requested non-preferred agent). See the PDL for the list of preferred Antihemophilia Agents at: https://papdl.com/preferred-drug-list

Q18. The request is for all other non-preferred factor replacement Antihemophilia Agents. If YES, go to 19. If NO, go to 21.

☐ Yes ☐ No

Q19. The member meets one of the following:

☐ Has documentation of failure to achieve clinical goals with the preferred Antihemophilia Agent(s) approved or medically accepted for the beneficiary's diagnosis or indication,

☐ Has a contraindication or an intolerance to the preferred Antihemophilia Agent(s) approved or medically accepted for the beneficiary's diagnosis or indication,

☐ Has a diagnosis for which no preferred Antihemophilia Agents are appropriate

Q20. The member meets both of the following:

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred Antihemophilia Agent	☐ Has documentation from the prescriber of a clinical reason why the beneficiary should continue to use the non-preferred agent (e.g., has a history of inhibitors and has not developed inhibitors while using the requested non-preferred agent). See the PDL for the list of preferred Antihemophilia Agents at: https://papdl.com/preferred-drug-list;

Q21. For a non-factor replacement Antihemophilia Agent, for hemophilia A, has one of the following diagnoses:

If YES, go to 23. If NO, go to 22.

☐ Severe congenital hemophilia A,

☐ Congenital hemophilia A with inhibitors,

☐ Congenital hemophilia A and a history of at least one spontaneous episode of bleeding into a joint or other serious bleeding event,

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☐ Acquired hemophilia A (emicizumab only)

Q22. For a non-factor replacement Antihemophilia Agent, for hemophilia B, has one of the following diagnoses:

☐ Severe congenital hemophilia B,
☐ Congenital hemophilia B with inhibitors,
☐ Congenital hemophilia B and a history of at least one spontaneous episode of bleeding into a joint or other serious bleeding event

Q23. For a non-preferred non-factor replacement Antihemophilia Agent, one of the following:

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred non-factor replacement Antihemophilia Agents approved or medically accepted for the beneficiary's diagnosis

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred non-factor replacement Antihemophilia Agent (does not apply to non-preferred biologics when a corresponding biosimilar/brand biologic/unbranded biologic is preferred). See the PDL for the list of preferred Antihemophilia Agents at: https://papdl.com/preferred-drug-list.

Q24. Additional Information:

Prescriber Signature

Date

v2026