Health Partners Plans

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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. Is this a request for continuation with the requested drug (i.e., This medication was previously approved by a prior authorization)?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed for an indication that is included in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the requested product prescribed by a hematologist or hemophilia treatment center practitioner?

☐ Yes ☐ No

Q5. Does the patient have a history of contraindication to the requested medication?

☐ Yes ☐ No

Q6. Is this request for a non-preferred antihemophilia agent?

☐ Yes ☐ No

Q7. Is this a request for a non-preferred extended half-life factor VIII replacement agent?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Does the patient have documented failure to achieve clinical goals or a history of contraindication or intolerance to the preferred extended half-life factor VIII replacement agents approved or medically accepted for the diagnosis or indication? Note: Please attach documentation.

☐ Yes ☐ No

Q9. Does the patient have both of the following: A) Current history [within the past 90 days] of being prescribed the requested drug and B) Documentation from the prescriber of a medical reason to continue the non-preferred extended half-life factor VIII replacement agent (e.g. a history of inhibitors and has not developed inhibitors while using the requested agent)? Note: Please attach documentation.

☐ Yes ☐ No

Q10. Is this a request for a non-preferred extended half-life factor IX replacement agent?

☐ Yes ☐ No

Q11. Does the patient have documented failure to achieve clinical goals or a history of contraindication or intolerance to the preferred extended half-life factor IX replacement agents approved or medically accepted for the diagnosis or indication? Note: Please attach documentation.

☐ Yes ☐ No

Q12. Does the patient have a history of contraindication to the requested medication?

☐ Yes ☐ No

Q13. Does the patient have both of the following: A) Current history [within the past 90 days] of being prescribed the requested drug and B) Documentation from the prescriber of a medical reason to continue the non-preferred extended half-life factor IX replacement agent (e.g. a history of inhibitors and has not developed inhibitors while using the requested agent)? Note: Please attach documentation.

☐ Yes ☐ No

Q14. Is this a request for a bypassing agent (e.g. FEIBA, NovoSeven RT)?

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of hemophilia A with inhibitors?

☐ Yes ☐ No

Q16. Does the patient have any of the following: A) Documented failure to achieve clinical goals with Hemlibra (emicizumab), B) Documentation from the prescriber of a medical reason why Hemlibra cannot be used, C) A current history [within the past 90 days] of being prescribed the requested agent for routine prophylaxis?

☐ Yes ☐ No

Q17. Does the patient have a diagnosis of hemophilia B with inhibitors?

☐ Yes ☐ No

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Q18. . Does the patient have a diagnosis of one of the following: A) Hemophilia A with inhibitors or B) Hemophilia B with inhibitors?

☐ Yes ☐ No

Q19. Does the patient have documented failure to achieve clinical goals or a history of contraindication or intolerance to the preferred antihemophilia agents approved or medically accepted for the diagnosis or indication? Note: Please attach documentation.

☐ Yes ☐ No

Q20. Does the patient have both of the following: A) Current history [within the past 90 days] of being prescribed the requested drug and B) Documentation from the prescriber of a medical reason to continue the non-preferred antihemophilia agent (e.g. a history of inhibitors and has not developed inhibitors while using the requested agent)? Note: Please attach documentation.

☐ Yes ☐ No

Q21. Is this request for Hemlibra?

☐ Yes ☐ No

Q22. Does the patient have one of the following: A) diagnosis of hemophilia A with inhibitors; B) diagnosis of severe hemophilia A or C) diagnosis of hemophilia A and a history of at least 1 spontaneous episode of bleeding into a joint or other serious bleeding event?

☐ Yes ☐ No

Q23. Has the patient demonstrated tolerability and a positive clinical response to the requested drug? Note: Please attach documentation.

☐ Yes ☐ No

Q24. Is the requested drug prescribed for an indication that is included in the Food and Drug Administration (FDA) approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q25. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q26. Is the requested drug prescribed by a hematologist or hemophilia treatment center practitioner?

☐ Yes ☐ No

Q27. Does the patient have a history of contraindication to the requested medication?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q28. Requested Duration:

☐ 12 months

Q29. Additional Information:

Prescriber Signature

Date

Updated for 2022