

## **Hemophilia Product Prior Authorization Form**

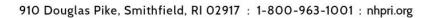
Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries and fax to 1-844-639-7906 or call 401-427-8200. All lab results must be faxed in.

## This request form pertains to the following products:

Feiba	Helixate FS	Alphanate	Hemlibra	Wilate
Feiba NF	Kogenate FS	Humate-P	BeneFIX	Idelvion
NovoSeven RT	Novoeight	AlphaNine SD	Ixinity	Vonvendi
Hemofil M	Recombinate	Mononine	Rixubis	Afstyla
Koate-DVI	Xyntha	Bebulin	Alprolix	Hemlibra
Monoclate-P	Adynovate	Kovaltry	Coagadex	Jivi
Nuwiq	Eloctate	Profilnine	Corifact	
Advate	Obizur	Rebinyn	Tretten	

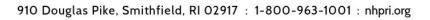
## I. Demographic Information

Patient Information		
First Name	Last Name	Patient Gender
Patient DOB	Patient Phone #	Alternative Phone #
Patient Address:		
City	State	Zip code
Provider Information		
Prescriber Name	Contact Name	Contact Phone #
NPI	Fax#	
Prescriber Address:		
City	State	Zip code





Rendering Provider (Disp	ensing Phar	macy) I	nformat	ion			
Pharmacy Name				NPI			NABP
							_
Contact Name		Phone #	!			Fax	#
Insurance Information							
Policy Holder Name			ID# of	Insurance C	Card		
Name of Insurance Compar	ny		Group	#			_
Primary Diagnosis							
□ Congenital Hemophilia □ Acquired Hemophilia A □ Hemophilia B (Congen □ von Willebrand Diseas □ Congenital Factor XIII I □ Congenital Factor X De □ Congenital Factor VII I □ Glanzmann's Thromba	A (Acquired I lital Factor IX se Deficiency A-subunit De eficiency Deficiency	Factor VI ( Deficie	III Deficie ncy)	• •			
ICD 10 Code							
Patient Inventory (Medica	ation on Han	nd)					
Total Number of Doses on Hand	Total Units	on Hand	d (IU)		Date Ver	rified	
Clinical Information							
Name of Treating Facility							





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**Product Name** 

910 Douglas Pike, Smithfield, RI 02917: 1-800-963-1001: nhpri.org

Was the patient on a differ	ent factor product previou	usly?	
☐ Yes			
□ No	nd roscon for product swi	tching:	
	nd reason for product swi	g	
Member's Height	Member's Weight		Severity of Disease
			☐ Mild (6% to 25% factor level)
			☐ Moderate (1% to 5% factor level)
			Severe (< 1% factor level)
Dose (IU)	Number of Doses Reque	ested	Total Dose Requested (IU)
Dosing Instructions		Retrospectiv	e request?
		☐ Yes	
		□ No	
Type of Use (Check all that	applies)	Place of Adm	inistration:
☐ Episodic		<u> </u>	e infusion vatient Hemophilia Treatment Center
<ul><li>☐ Prophylaxis</li><li>☐ Acute Bleeding Episo</li></ul>	de	(HTC	•
☐ Dental Procedure		☐ Outp	patient Hospital
Date of Procedure:			ider's office administration
☐ Surgical Prophylaxis  Date of Procedure:			
Number and Location of bl	eeds in the past 12 month	s:	
Does the patient have a dia	agnosis confirmed by bloo	d coagulation	testing?
☐ Yes			
□ No			

to prediction in the second	regarding factor levels
☐ Factor VIII for Hemophilia A	910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-100
☐ Factor X for Hereditary Factor X D	·
•	(III or Factor XXIII A-subunit Deficiencies
☐ VW Factor for von Willebrand Dis	sease
a. Baseline Factor Level	
b. Date of Factor Level	
c. Desired (Target) Factor Le	vel
oes the patient have inhibitors to factor	products?
☐ Yes	
□ No	
so, are documentations of inhibitor test	ts attached? (e.g., Bethesda inhibitor assay)
☐ Yes	
□ No	
las the patient previously received Immu	une Tolerance Induction (ITI)?
☐ Yes	
□ No	
If yes, date and duration of the trial ar	nd patient response:
vid the patient experience at least two do	ocumented episodes of spontaneous bleeding into the joints?
☐ Yes	
□ No	
or minimally treated nationts /< E0 ovno	sure days to factor products) previously receiving a different
actor product, how often will inhibitor to	sating has partares ad

was a pharmacokinetics OF RHODE IS Ves	LAND	) TM	9	10 Douglas Pike, Sr	nithfield, R	1 02917 : 1-800-963-1001	: nl
□ No							
If so, are PK testing resul	ts atta	ched?					
☐ Yes							
□ No							
If patient has a diagnosis	of Gla	ınzman	nn's Thromb	asthenia, has the p	atient triec	platelet transfusions?	
☐ Yes							
□ No							
If yes, date of the tria	ıl and p	oatient	response: _				
							-
If the patient has a diagn	osis of	f von W	Villebrand D	isease (VWD), has	the patient	tried desmopressin?	
If the patient has a diagn	nosis of	f von W	/illebrand D	isease (VWD), has	the patient	tried desmopressin?	
If the patient has a diagn  ☐ Yes ☐ No	nosis of	f von W	Villebrand D	isease (VWD), has	the patient	tried desmopressin?	
☐ Yes ☐ No					the patient	tried desmopressin?	
☐ Yes☐ No If no, is the patient c					the patient	tried desmopressin?	
☐ Yes☐ No If no, is the patient c☐ Yes					the patient	tried desmopressin?	
☐ Yes☐ No  If no, is the patient c☐ Yes☐ No	contrair	ndicate	ed to desmo	ppressin?	the patient	tried desmopressin?	
☐ Yes☐ No If no, is the patient c☐ Yes	contrair	ndicate	ed to desmo	ppressin?	the patient	tried desmopressin?	
☐ Yes☐ No  If no, is the patient c☐ Yes☐ No	contrair	ndicate r contr	ed to desmo	ppressin?			
☐ Yes☐ No  If no, is the patient c☐ Yes☐ No  If yes, what is the rea	contrain ason for odes, p	ndicate r contr	ed to desmo	ppressin?	nal informa		
☐ Yes☐ No  If no, is the patient c☐ Yes☐ No  If yes, what is the rea  For acute bleeding episo	econtrain ason for odes, p	ndicate r contr please j	ed to desmo raindication: provide the	opressin?	nal informa	ation:	
☐ Yes☐ No  If no, is the patient c☐ Yes☐ No  If yes, what is the rea  For acute bleeding episo	eson for odes, p	ndicate r contr please p	ed to desmo	opressin?	nal informa	ation:	