



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecure-forproviders/pharmacy

Hemophilia Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information							
Member Name (first & last):		Date of Birth:		Gender:		Height:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
Member ID:		City:		State:		Weight:	
Prescribing Provider Information							
Provider Name (first & last):		Specialty:		NPI#		DEA#	
Office Address:		City:		State:		Zip Code:	
Office Contact:			Office Phone			Office Fax:	
Dispensing Pharmacy Information							
Pharmacy Name:			Pharmacy Phone:			Pharmacy Fax:	
Requested Medication Information							
Request is for (specify medication name):							
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No				Diagnosis:		ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
What medication(s) has member tried and failed for this diagnosis? Please specify below.							
Directions for Use:			Strength:			Dosage Form:	
			Quantity:	Day Supply:		Duration of Therapy/Use:	
Turn-Around Time for Review							
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____				
Clinical Information							
Does member have Hemophilia A or B OR Von Willebrand disease with current serious OR life-threatening bleeds?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Hemophilia A (Inherited Factor VIII Deficiency)							
Is there <1% of normal Factor VIII (less than 0.01 IU/mL)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have history of one or more episodes of spontaneous bleeding into joints (for example, routine bleeding prophylaxis, hemorrhage, perioperative bleeding)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:							
Was member screened for inhibitors since last approval?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is an inhibitor present?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Hemophilia B (Inherited Factor IX Deficiency)							
Is there < 1% of normal Factor IX (less than 0.01 IU/mL)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have history of one or more episodes of spontaneous bleeding into joints (for example, routine bleeding prophylaxis, hemorrhage, perioperative bleeding)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:							
Was member screened for inhibitors since last approval?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is an inhibitor present?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If an inhibitor is present, is there a treatment plan to		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A

		address inhibitors as appropriate?				
<input type="checkbox"/> Von Willebrand Disease						
Does member have a laboratory confirmed diagnosis?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have history of bleed (for example, prolonged wound bleed, post-surgical or dental bleed, nosebleeds, menorrhagia, excessive bruising, or family history of bleeding or bleeding disorder)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Novo-Seven RT (Recombinant Activated Factor VII Concentrate (Factor VIIa))						
Member has ONE of the following FDA approved indications (check one):	<input type="checkbox"/> Acquired hemophilia		<input type="checkbox"/> Glanzmann's thrombasthenia, when refractory to platelet transfusions, with or without antibodies to platelets			
	<input type="checkbox"/> Congenital Factor VII deficiency					
	<input type="checkbox"/> Hemophilia A or B with Inhibitors					
Is treatment for hemorrhagic complications OR prevention of bleeds in surgical OR invasive procedures?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:						
Is an inhibitor present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Feiba (Activated Prothrombin Complex Concentrate)						
Will Feiba be used for Hemophilia A or Hemophilia B with inhibitors?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will Feiba be used for the treatment of hemorrhagic complications, or prevention of bleeds, in surgical, or invasive procedures, or routine prophylaxis?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:						
Is an inhibitor present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Obizur						
Will Obizur be used for acquired Hemophilia A in adults (for treatment of bleeding episodes)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is baseline anti-porcine Factor VIII inhibitor titer NOT > 20 Bethesda Units?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Renewal ONLY:						
Is inhibitor present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Hemlibra						
Will Hemlibra be used for prophylaxis of Hemophilia A with or without inhibitors?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there severe disease with documentation showing <1% of normal Factor VIII (<0.01 IU/mL)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is disease mild or moderate with documentation showing ≥1% of normal Factor VIII (≥0.01 IU/mL)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation showing at least TWO episodes of bleeding into the joints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Members without inhibitors have tried and failed OR have documented contraindications to TWO prophylactic factor VIII replacement products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Will medication be used for treatment of acute bleeds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider confirms that member will D/C any use of factor VIII products as prophylactic therapy while on Hemlibra (on-demand usage may be continued)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cumulative amount of >100 U/kg/24hrs of activated prothrombin complex concentrate has not been GIVEN for 24 HRS or more. (examples of activated prothrombin complex concentrate include Feiba, Novoseven RT)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:						
Is inhibitor present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Additional information the prescribing provider feels is important to this review. Please specify below OR submit medical records.						

[Empty box for chart notes]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned
Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.