CREDENCE

Hemophilia Product Prior Authorization Form

Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries and **fax to 1-888-656-0841**. 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	Novoeight	AlphaNine SD	Ixinity	Vonvendi
RT Hemofil M	Recombinate	Mononine	Rixubis	Afstyla
Koate-DVI	Xyntha	Bebulin	Alprolix	
Monoclate-P	Adynovate	Kovaltry	Coagadex	
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 (Dispensing Pharmacy) Information		
Pharmacy Name	NPI	NABP
Contact Name	Phone #	Fax #

Insurance Information	
Policy Holder Name	ID# of Insurance Card
Name of Insurance Company	Group #

Primary Diagnosis

- ☐ Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- ☐ Acquired Hemophilia A (Aquired Factor VIII Deficiency)
- ☐ Hemophilia B (Congenital Factor IX Deficiency)
- ☐ von Willebrand Disease
- ☐ Congenital Factor XIII Deficiency
- ☐ Congenital Factor XIII A-subunit Deficiency
- ☐ Hereditary Factor X Deficiency
- ☐ Congenital Factor VII Deficiency
- ☐ Glanzmann's Thrombasthenia

ICD 10 Code

Patient Inventory (Medication on Hand)		
Total Number of Doses on Hand	Total Units on Hand (IU)	Date Verified

Clinical Information

Name of Treating Facility

Treatment status ☐ Treatment-naïve ☐ Treatment-experienced	Product Name

Was the patient on a different factor product previously?

☐ Yes
☐ No

If yes, which product and reason for product switching:_____

_____

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 Requested	Total Dose Requested (IU)

Dosing Instructions	Retrospective request? ☐ Yes ☐ No
Type of Use (Check all that applies) ☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure Date of Procedure:_____ ☐ Surgical Prophylaxis Date of Procedure:_____	Place of Administration: ☐ Home infusion ☐ Outpatient Hemophilia Treatment Center (HTC) ☐ Outpatient Hospital ☐ Provider's office ☐ Self-administration

Number and Location of bleeds in the past 12 months:

Does the patient have a diagnosis confirmed by blood coagulation testing?

☐ Yes
☐ No

Please provide the following information regarding factor levels

- ☐ Factor VIII for Hemophilia A
- ☐ Factor IX for Hemophilia B
- ☐ Factor X for Hereditary Factor X Deficiency
- ☐ Factor XIII for Congenital Factor XIII or Factor XXIII A-subunit Deficiencies
- ☐ VW Factor for von Willebrand Disease

a. Baseline Factor Level _____

b. Date of Factor Level_____

c. Desired (Target) Factor Level_____

Does the patient have inhibitors to factor products?

- ☐ Yes
- ☐ No

If so, are documentations of inhibitor tests attached? (e.g., Bethesda inhibitor assay)

- ☐ Yes
- ☐ No

Has the patient previously received Immune Tolerance Induction (ITI)?

- ☐ Yes
- ☐ No

If yes, date and duration of the trial and patient response: _____

_____

Did the patient experience at least two documented episodes of spontaneous bleeding into the joints?

- ☐ Yes
- ☐ No

For minimally treated patients (< 50 exposure days to factor products) previously receiving a different factor product, how often will inhibitor testing be performed?

_____

Was a pharmacokinetics (PK) test performed for this patient?

- ☐ Yes
- ☐ No

If so, are PK testing results attached?

- ☐ Yes
- ☐ No

If patient has a diagnosis of Glanzmann's Thrombasthenia, has the patient tried platelet transfusions?

- ☐ Yes
- ☐ No

If yes, date of the trial and patient response: _____

If the patient has a diagnosis of von Willebrand Disease (VWD), has the patient tried desmopressin?

- ☐ Yes
- ☐ No

If no, is the patient contraindicated to desmopressin?

- ☐ Yes
- ☐ No

If yes, what is the reason for contraindication:_____

For acute bleeding episodes, please provide the following additional information:

Location of Bleed	Type of Bleed	Start Date of Bleed:	End Date of Bleed:
	☐ Minor ☐ Moderate ☐ Major		

Number of Doses Used	Dose (IU)	Total Amount Used (IU)

To view current hemophilia policies and the Hemophilia Product Prior Authorization Form, please visit **Policies.CredenceBlue.com**.