Hemlibra (emicizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Congenital Hemophilia A with inhibitors ☐ Congenital Hemophilia A without inhibitors ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Does the patient have a diagnosis of congenital hemophilia A, as corroborated by a submitted lab report documenting factor VIII deficiency or dysfunction?* □ **Yes** □ **No**

Is Hemlibra prescribed by a hematologist or a clinician in a hemophilia clinic? □ **Yes** □ **No**

For diagnosis of Congenital Hemophilia A with inhibitors, please answer the following:
Does the patient have a history of a high titer of factor VIII inhibitors (neutralizing anti-factor VIII alloantibodies) equaling 5 Bethesda units per milliliter or greater, as corroborated by a submitted lab report?* □ **Yes** □ **No**

Select if the patient has received EPISODIC or PROPHYLACTIC treatment for at least six months with the following bypassing agent(s):
□ **Activated prothrombin complex concentrate**
□ **Recombinant factor VIIa**

Has the patient experienced at least 6 bleeding events in the previous 6 months while receiving EPISODIC treatment with at least one of the aforementioned bypassing agents? □ **Yes** □ **No**

Has the patient experienced at least 2 bleeding events in the previous 6 months while receiving PROPHYLACTIC treatment with at least one of the aforementioned bypassing agents? □ **Yes** □ **No**
Please provide lab report.

For diagnosis of Congenital Hemophilia A without inhibitors, please answer the following:
Does patient have documentation of optimally dosed prophylactic factor VIII product is ineffective for the prevention of spontaneous bleeding events(such as continuing to have bleeding events or arthroscopic changes within a target joint)? □ **Yes** □ **No Please submit chart documentation.**

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Does patient have severe hemophilia A without inhibitors as documented with endogenous factor VIII levels less than 1% of normal factor VIII (<0.01IU/ml),? □ Yes □ No Please submit lab report.

Does patient have moderate hemophilia A without Inhibitors as documented with endogenous factor VIII levels ≥ 1% <5% (greater than or equal to 0.01IU/ml to less than 0.05IU/ml)? □ Yes □ No Please submit lab report.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909