Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
HEMLIBRA (Emicizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **HEMLIBRA (Emicizumab)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a hematologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____

Clinical Criteria:
Hemophilia A WITHOUT inhibitors:

1. Does the member have a diagnosis of Hemophilia A? **AND**
   □ No □ Yes
2. Prescribed for routine prophylaxis? **AND**
   □ No □ Yes
3. Does the member have documentation of failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of formulary prophylactic factor VIII replacement products?
   □ No □ Yes

-**OR-**

Hemophilia A WITH inhibitors:

1. Member has developed high-titer factor VIII inhibitors [≥5 Bethesda units (BU)]? **AND**
   □ No □ Yes
2. Prescribed for routine prophylaxis?
   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Is there documentation of positive clinical response to Hemlibra therapy, **AND**
   □ No □ Yes
2. Office or telephone visit with a specialist in the past 12 months?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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