

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).** <u>Please complete all sections, incomplete forms will delay processing.</u> <u>Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104</u>. 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: <a href="http://www.providers.kaiserpermanente.org/mas/formulary.html">http://www.providers.kaiserpermanente.org/mas/formulary.html</a>

|   | 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, special | ist name and specialty:    |                |
| Prescriber Name:                        | Specialty:                 | NPI:           |
| Prescriber Address:                     |                            |                |
| Prescriber Phone #:                     | Prescriber Fax #:          |                |
|   | 3 – Pharmacy Information   |                |
| Pharmacy Name:                          | Pharmacy NPI:              |                |
| Pharmacy Phone #                        | Pharmacy Fax #:            |                |
|   | 4 – Drug Therapy Requested |                |
| Drug 1: Name/Strength/Formulation       | n:                         |                |
|   |                            |                |
|   |                            |                |
| Drug 2: Name/Strength/Formulation       | 1:                         |                |
| Sig:                                    |                            |                |
| 1                                       |                            |                |

## 5- Diagnosis/Clinical Criteria

| 1       | Is this request for initial or continuing therapy?  |
|---------|---|
| Τ.      | □ Initial therapy □ Continuing therapy, State date:   |
| 2.      | Indicate the Member's diagnosis for the requested medication:   |
| ۷.      | mulcate the Member 3 diagnosis for the requested medication.  |
| Hemop   | philia A WITHOUT inhibitors:  |
| 3.      | Does the member have a diagnosis of Hemophilia A? <b>AND</b>  |
| ٥.      | □ No □ Yes  |
| 4.      | Prescribed for routine prophylaxis? AND   |
|         | □ No □ Yes  |
| 5.      | 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 VII replacement products?  □ No □ Yes |
| -01     |   |
|         |   |
| Hemop   | philia A WITH inhibitors:   |
| 6.      | Member has developed high-titer factor VII inhibitors [≥5 Bethesda units (BU)]? <b>AND</b>  |
| ٥.      | □ No □ Yes  |
| 7.      | Prescribed for routine prophylaxis?   |
|         | □ No □ Yes  |
| For Coi | ntinuation 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   |
| Additio | onal Information – Please submit chart notes/medical records for the patient that are applicable to this request.   |
|         | e any additional supporting information that should be taken into consideration:  |
|         |   |
|         |   |
|         | ify that the information provided is accurate. Supporting documentation is available for State audits.  |
| Prescri | iber Signature: Date:   |
|         |   |
| Diago N | Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is   |
|         | and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of   |
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