PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Hemlibra® (emicizumab-kxwh)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:

☐ Hemlibra 30 mg/mL
☐ Hemlibra 60 mg / 0.4 mL
☐ Hemlibra 105 mg / 0.7 mL
☐ Hemlibra 150 mg/mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for one dose of Hemlibra is $373,000.

Precertification Requirements

Before this drug is covered, documentation must be submitted to support that the patient meets all of the following requirements:

1. Diagnosis of Hemophilia A with factor VIII inhibitors (documentation of the presence of inhibitors must be submitted to Priority Health)

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017

Last reviewed 01/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ *Hemophilia A with factor VIII inhibitors (documentation of inhibitors must be submitted to Priority Health)*

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

Additional information

Note: Coverage of Hemlibra is limited to the FDA approved dosing of 3 mg/kg for the first 4 weeks of therapy, then 1.5 mg/kg weekly thereafter.
Additionally, when approved, Hemlibra must be obtained from a participating Hemophilia Specialty Pharmacy as noted in Medical Policy 91569.

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