CAREFIRST COMMERCIAL - NON-RISK - FORMULARY 1 - SPC
Hemo Hympavzi SGM*

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Hemo Hympavzi SGM*.

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Hympavzi

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - ☐ Hemophilia A (congenital factor VIII deficiency) (If checked, go to 2)
   - ☐ Hemophilia B (congenital factor IX deficiency) (If checked, go to 20)
   - Other, please specify. (If checked, no further questions) _____
2. Will the requested drug be prescribed by or in consultation with a hematologist? **Y** ☐ **N** ☐
3. Is the request for continuation of therapy? **Y** ☐ **N** ☐
4. Does the patient have any detectable or documented history of factor VIII inhibitors? **Y** ☐ **N** ☐
5. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ACTION REQUIRED: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds). **Y** ☐ **N** ☐
6. Will the requested drug be used in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate) for prophylactic use? **Y** ☐ **N** ☐
7. What is the patient's age?
   - ☐ 12 years of age or older (If checked, go to 8)
   - ☐ Less than 12 years of age (If checked, no further questions)
8. Is the patient's weight greater than or equal to 35 kg? **Y** ☐ **N** ☐

9.	Does the patient have any detectable or documented history of factor VIII inhibitors? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting the absence of factor VIII inhibitors (lab test results required).	Y ☐	N ☐
10.	Does the patient have severe factor VIII deficiency (defined as factor VIII level of less than 1%)? ACTION REQUIRED: If Yes, please attach chart notes, lab tests documenting severe factor VIII deficiency (factor VIII level of less than 1%).	Y ☐	N ☐
11.	Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?	Y ☐	N ☐
12.	Will the patient be using the requested drug to treat breakthrough bleeding?	Y ☐	N ☐
13.	Has the patient had an inadequate response, intolerance, or contraindication to compliant use of a factor VIII product (e.g., Advate, Adynovate, Eloctate)?	Y ☐	N ☐
14.	Has the patient had at least 6 acute bleeding episodes in the previous 6 months?	Y ☐	N ☐
15.	Does the patient have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease?	Y ☐	N ☐
16.	Does the patient have unstable or abnormal hepatic, biliary, or renal function/disease?	Y ☐	N ☐
17.	Will the requested drug be used in combination with Hemlibra?	Y ☐	N ☐
18.	Has the patient previously received treatment with a gene therapy product (e.g., Roctavian) for the treatment of hemophilia A?	Y ☐	N ☐
19.	Will prophylactic use of factor VIII products be discontinued prior to starting therapy with the requested drug?	Y ☐	N ☐
20.	Will the requested drug be prescribed by or in consultation with a hematologist?	Y ☐	N ☐
21.	Is the request for continuation of therapy?	Y ☐	N ☐
22.	Does the patient have any detectable or documented history of factor IX inhibitors?	Y ☐	N ☐
23.	Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ACTION REQUIRED: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds).	Y ☐	N ☐
24.	Will the requested drug be used in combination with factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use?	Y ☐	N ☐
25.	What is the patient's age?		
	12 years of age or older (If checked, go to 26)	☐	
	Less than 12 years of age (If checked, no further questions)	☐	
26.	Is the patient's weight greater than or equal to 35 kg?	Y ☐	N ☐
27.	Does the patient have moderately severe to severe factor IX deficiency (defined as factor IX level of less than or equal to 2%)? ACTION REQUIRED: If Yes, please attach chart notes, lab tests documenting moderately severe to severe factor IX deficiency (factor IX level of less than or equal to 2%).	Y ☐	N ☐
28.	Does the patient have any detectable or documented history of factor IX inhibitors? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting the absence of factor IX inhibitors (lab test results required).	Y ☐	N ☐
29.	Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?	Y ☐	N ☐
30.	Will the patient be using the requested drug to treat breakthrough bleeding?	Y ☐	N ☐
31.	Has the patient had an inadequate response, intolerance, or contraindication to compliant use of a factor IX product (e.g., Alprolix, Ixinity, Rebinyn)?	Y ☐	N ☐
32.	Has the patient had at least 6 acute bleeding episodes in the previous 6 months?	Y ☐	N ☐
33.	Does the patient have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease?	Y ☐	N ☐
34.	Does the patient have unstable or abnormal hepatic, biliary, or renal function/disease?	Y ☐	N ☐
35.	Has the patient previously received treatment with a gene therapy product (e.g., Hemgenix) for the treatment of hemophilia B?	Y ☐	N ☐
36.	Will prophylactic use of factor IX products be discontinued prior to starting therapy with the requested drug?	Y ☐	N ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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