PA Request Criteria

00-000000000

232556

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
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 2) ☐
   - 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. 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** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Will the requested drug be used in combination with bypassing agents, factor VIII products (e.g., Advate, Adynovate, Eloctate) or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use? **Y** ☐ **N** ☐
6. What is the patient's age?
   - 12 years of age or older (If checked, go to 7) ☐
   - Less than 12 years of age (If checked, no further questions) ☐
7. Does the patient have severe factor VIII (defined as factor VIII level of less than 1%) or severe factor IX (defined as factor IX level of less than or equal to 2%) deficiency? ACTION REQUIRED: If Yes, please attach chart notes, lab tests documenting severe factor VIII (factor VIII level of less than 1%) or severe factor IX (defined as factor IX level of less than 2%) deficiency. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
8. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? **Y** ☐ **N** ☐
9. Will the patient be using the requested drug to treat breakthrough bleeding? **Y** ☐ **N** ☐
10. Does the patient have co-existing coagulation disorders (other than hemophilia A or B)? **Y** ☐ **N** ☐

11. Does the patient have a history of arterial or venous thromboembolism, significant valvular disease or atrial fibrillation, or co-existing thrombophilic disorder (e.g., Factor V Leiden mutation)? **Y** ☐ **N** ☐

12. Does the patient have a history of symptomatic gallbladder disease? **Y** ☐ **N** ☐

13. Does the patient have a history of or is planning to undergo immune tolerance treatment? **Y** ☐ **N** ☐

14. Please indicate antithrombin (AT) activity at baseline: ACTION REQUIRED: Please attach antithrombin (AT) activity baseline lab results .

    Greater than 60 % (If checked, go to 15) ☐

    Less than 60 % (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

15. Does the patient have alanine transaminase (ALT) and or aspartate aminotransferase (AST) greater than 1.5 times the upper limit of normal (ULN)? ACTION REQUIRED: If Yes, please attach hematologic assessments. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

16. Does the patient have clinically significant liver disease? ACTION REQUIRED: If Yes, please attach hepatic assessment. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

17. Will the requested drug be used in combination with Alhemo, Hemlibra, or Hympavzi? **Y** ☐ **N** ☐

18. Has the patient previously received treatment with a gene therapy product (e.g., Beqvez, Hemgenix, Roctavian) for the treatment of hemophilia A or hemophilia B? **Y** ☐ **N** ☐

19. Will prophylactic use of bypassing agents, factor VIII products and factor IX products be discontinued no later than 7 days after the initial dose of the requested drug? **Y** ☐ **N** ☐

20. Does the provider attest that AT activity and liver enzymes will be monitored per the protocol outlined in the prescribing information? **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