Clotting Factor Prior Authorization Form

Incomplete forms will not be reviewed

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Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Prescription Information

❑ New request ❑ Reauthorization ❑ Dose change request

❑ Prophylactic ❑ Procedure ❑ On-demand ❑ Immune Tolerance Induction (ITI)

Up to six doses per claim may be submitted for on-demand use on patients with infrequent bleeds

Antihemophilic medication: _____ Unit: _____ Requested correction factor: _____ %

(up to ±10% correction factor is allowed)

Direction: _____

As needed for breakthrough bleeding regimen: _____

Diagnosis: ❑ Hemophilia A ❑ Hemophilia B ❑ Hemophilia C ❑ Von Willebrand ❑ Other: _____

Degree of factor VIII or IX deficiency:

❑ Severe (<0.01 iu/ml or < 1% of normal) ❑ Moderate (0.01-0.05 iu/ml or 1-5%) ❑ Mild (0.05-0.4 iu/ml or 5-40%)

Most recent factor level: _____ % Date: _____ (attach most recent assay)

Inhibitors: ❑ No ❑ Historical ❑ Current

Inhibitor level **(**Bethesda Assay Test): _____BU Date: _____

Previously tried and failed treatments, including dosage: _____

_____

For ITI use:

Anticipated length of therapy: _____

Initial approval is for 6 months. Submit a new PA along with progress note and Bethesda assay titers for any extension request

Lab results after six months of ITIT: Clotting factor level: _____ Date: _____

Inhibitor level: _____ Date: _____

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❑ Decrease ITI dosing regimen due to: _____

❑ Continue ITI after 6 months due to: _____

ITI is no longer considered medically necessary when following criteria are met:

- Inhibitor levels become undetectable (negative Bethesda assay) OR
- Normal Recovery of Factor VIII levels (defined as at ≥ 66% of expected level and a half-life of >6 hours are considered sufficient normal pharmacokinetic responses to characterize a complete tolerance)

ITI dosage may be gradually tapered off to a prophylactic dose upon successful treatment.

I attest that

❑ Patient's lab/test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature_____ Date_____