Hemlibra® (emicizumab-kxwh) Prior Authorization Form

Incomplete forms will not be reviewed

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: ______________________

Diagnosis: ❑ Hemophilia A ❑ Other: ____________________

Prescription Information

Note: Hemlibra is currently not used in combination with Immune Tolerance Induction

❑ New start ❑ Renewal request ❑ Change in dosage

❑ Dose: _______________ Frequency: _____________________

Strength: ______________________

As needed for breakthrough bleeding regimen: ____

Clinical Information

Degree of clotting factor deficiency: ❑ Severe ❑ Moderate ❑ Mild

Most recent factor VIII level ______ % *(attach most recent assay)* Date: ____________

Inhibitors *(Bethesda Assay Test required)*: ❑ No ❑ Historical ❑ Current

Recent inhibitor level: _______________ Date: __________________

1. Current hemophilia regimen. Prophylaxis regimen: __________________ As needed regimen: ________________

Following questions apply to patient with Inhibitors:

2. Has the patient tried and failed Immune Tolerance Induction (ITI)? ❑ Yes ❑ No
3. Is the patient currently using a bypassing agent? ❑ Yes ❑ No

❑ Submit most recent progress note and pertinent lab/test results for both initial and renewal requests. Objective clinical benefits such as less spontaneous bleeding episodes should be evident in the note for renewal request.

Is the patient utilizing Feiba® for breakthrough bleeding? ❑ Yes ❑ No *If yes, please confirm the following:*

❑ Patient will be monitored for thrombotic microangiopathy and thromboembolism.

❑ Hemlibra is not used concurrently with high dose Feiba® (>100 U/kg/24 hours).

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______________________