Print Reset

Alaska Medicaid

Hemlibra®

Prescribing/Treatment Plan Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

What is the members weight (in kg)? _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Refills: _____

Alaska Medicaid Hemlibra® Prior Authorization Form

Last Name: _____ First Name: _____

Is this a physician-administered drug? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

1. Is the prescriber affiliated with the regional hemophilia treatment center?
   ☐ Yes ☐ No
2. Does the prescriber attest that the patient will comply with the requirement to log infusions?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of hemophilia A and have documented congenital factor VIII deficiency confirmed by blood coagulation testing?
   ☐ Yes ☐ No
4. Is Hemlibra being used in combination with immune tolerance induction (ITI)?
   ☐ Yes ☐ No
5. Will this medication be used as routine prophylaxis to prevent or reduce bleeds?
   ☐ Yes ☐ No
6. **For renewals only**: Is there documentation of positive response, as evidenced by a reduction in spontaneous bleeds, which has been verified by the prescriber?
   ☐ Yes ☐ No

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____
(required)

Magellan Rx Management, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: (800) 331-4475

Fax this form to (888) 603-7696