Print Reset

Alaska Medicaid

Hemophilia/Bleeding Disorder 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: _____

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: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

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

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Last Name: _____ First Name: _____

CLINICAL INFORMATION

Diagnosis (ICD-10 Code):

- ☐ D66 – Hereditary factor VIII deficiency
- ☐ D67 – Hereditary factor IX deficiency
- ☐ D68.0 – Von Willebrand disease
- ☐ D68.311 – Acquired hemophilia
- ☐ D68.318 – Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
- ☐ Other ICD-10 code: _____

Diagnosis Confirmation: ☐ Genetic testing ☐ Factor levels (pre-treatment) ☐ Severe

Patient Clinical Information:

Factor level: _____ Date: _____

Severity: ☐ Severe (< 1%) ☐ Moderate (1–5%) ☐ Mild (> 5%)

Allergies: _____ Weight: _____ Height: _____

Access:

- ☐ Peripheral Butterfly

Phylaxis:

- ☐ PICC
- ☐ Implant Port
- ☐ Broviac®/Hickman®

Notes: _____

TREATMENT PLAN

Treatment Plan/Prep Date: _____ Therapy Start Date: _____

Authorization Start Date: _____ Authorization End Date: _____

Authorization Request Type:

☐ New ☐ Renewal ☐ Change

Treatment Duration:

☐ 3 months ☐ 6 months ☐ 9 months ☐ Other: _____

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Last Name: _____ First Name: _____

PRESCRIPTION INFORMATION

1. Is the prescriber affiliated with the regional Hemophilia Treatment Center?
   ☐ Yes ☐ No
2. Do enrolled Alaska Medicaid providers prescribing and dispensing clotting factor concentrates or clotting factor products agree to comply with standards of care in the Hemophilia Factor Program Standards of Care and Clinical Criteria for Use?
   ☐ Yes ☐ No
3. Please attest that the patient will comply with the requirement to log infusions.
   ☐ Yes ☐ No
4. Please attest that the pharmacy provider will maintain infusion logs and will review for the purpose of identifying variances in utilization frequency and will address compliance concerns with the patient.
   ☐ Yes ☐ No
5. For renewals: Has the patient demonstrated clinical stability on a prophylaxis regimen, resulting in reduced need for treatment of acute bleeding episodes?
   ☐ Yes ☐ No

Factor VIII (Recombinant, Antibody)

Product Name:

☐ Advate®	☐ Hemlibra®	☐ NovoEight®
☐ Adynovate®	☐ Idelvion®	☐ Nuwiq®
☐ Eloctate®	☐ Kogenate® FS	☐ Recombinate®
☐ Helixate® FS	☐ Kovaltry®	☐ Xyntha®

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Bleed:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

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Factor IX

Product Name:

- ☐ AlphaNine® SDVF
- ☐ Alprolix®
- ☐ Bebulin® VH
- ☐ Benefix®
- ☐ Idelvion®
- ☐ Ixinity®
- ☐ Mononine®
- ☐ Profilnine® SD
- ☐ Rixubis®

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Bleed:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Factor XIII

Product Name:

- ☐ Amicar® Syrup
- ☐ Amicar® Tablet
- ☐ Corifact®
- ☐ Lysteda™
- ☐ Stimate®
- ☐ Tretten®

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Bleed:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Von Willebrand

Product Name:

- ☐ Alphanate® SDHT
- ☐ Koate® DVI
- ☐ Humate P®
- ☐ Wilate®

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Bleed:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

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Last Name: _____ First Name: _____

Inhibitor Therapies

Product Name:

☐ Feiba® VH ☐ NovoSeven®

Prophylaxis:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Bleed:

Dose/Units/Kg: _____ Quantity: _____ Route: _____

Refills: _____ Frequency: _____

Other

☐ Other: _____

☐ Other: _____

☐ 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