ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Antihemophilia Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/State/Zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:	
Directions:	Quantity:	Refills:
Drug #2 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Is the medication prescribed by a hematologist or hemophilia treatment center practitioner?	☐Yes	☐No
Is the member currently being treated with the requested medication?	☐Yes – date of last dose: _____ ☐No	

Complete the section(s) below applicable to the member and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests

1. Request is for a NON-FACTOR REPLACEMENT Antihemophilia Agent (e.g., Alhemo, Hemlibra, Hympavzi, Qfitlia):

☐Has one of the following diagnoses:

Hemophilia A	Hemophilia B
☐severe congenital hemophilia A	☐severe congenital hemophilia B
☐congenital hemophilia A with inhibitors	☐congenital hemophilia B with inhibitors
☐congenital hemophilia A and a history of at least 1	☐congenital hemophilia B and a history of at least 1

spontaneous joint bleed or other serious bleeding event ☐ acquired hemophilia A (emicizumab only)	spontaneous joint bleed or other serious bleeding event

☐ **For a <u>non-preferred</u> non-factor replacement Antihemophilia Agent:**

☐ Tried and failed or cannot try (due to a contraindication or an intolerance) the preferred non-factor replacement agents approved or medically accepted for the member's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. Request is for a BYPASSING AGENT (eg, FEIBA NF, NovoSeven, Sevenfact):

☐ Has hemophilia A with inhibitors AND:

☐ Is using the requested medication for episodic/on-demand treatment OR intermittent/periodic prophylaxis

☐ Is using the requested medication for routine prophylaxis AND:

☐ Failed to achieve clinical goals with Hemlibra (emicizumab)

☐ Has a medical reason why Hemlibra (emicizumab) cannot be used

☐ Has been using the requested bypassing agent for routine prophylaxis within the past 90 days

☐ Has hemophilia B with inhibitors

☐ Has acquired hemophilia

☐ Has congenital factor VII deficiency

☐ Has Glanzmann's thrombasthenia

3. Request is for a <u>non-preferred</u> FACTOR VIII, FACTOR IX, or VWF:

☐ Both of the following:

☐ Has been using the requested medication within the past 90 days

☐ Has a medical reason to continue using the requested medication

☐ Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred FVIII, FIX, or FVIII/VWF medications with the same half-life (standard v. extended half-life), if applicable. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

☐ Has a diagnosis for which no preferred Antihemophilia Agents are appropriate. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

RENEWAL requests

☐ Experienced a positive clinical response since starting the requested medication

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)