ATRIO HEALTH PLANS

# Anti-Hemophilic

**FACTOR VIII (Human, Pegylated-Recombinant J7190, Factor VIII (Porcine) J7191, Fusion-Recombinant, Recombinant NOS) J7192, Afstyla J7210, Jivi J7208, Kovaltry J7211, Novoeight J7182, Nuwiq J7209, Obizur J7188, Xyntha J7185, Esperoct J7204, Eloctate J7205, Adynovate J7207**

**Prior Authorization Request**

**Medicare Part B Form**

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

| ☐ | **Standard Request– (72 Hours)** | ☐ | **Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy) |
|---|---|---|---|
| | Date Requested _____ | | |
| | Requestor _____ Clinic name: _____ Phone / Fax | | |

**MEMBER INFORMATION**

*Name:_____ *ID#:_____ *DOB:_____

_____

**PRESCRIBER INFORMATION**

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

*Name:_____ Phone:_____

*Address:_____ Fax:_____

**PROCEDURE / PRODUCT INFORMATION**

| HCPC Code | Name of Drug | Dose (Wt: _____ kg Ht:_____ ) | Frequency | End Date if known |
|---|---|---|---|---|
| | | | | |

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

**Diagnosis: ICD10**: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

## ACKNOWLEDGEMENT

**Request By (Signature Required): _____Date:_____ /____ /____**

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

## Prior Authorization Group – Coagulation Factors PA

### Drug Name(s):
**FACTOR VIII (Recombinant)**
**FACTOR VIII (Human)**
**FACTOR VIII (Porcine)**
**FACTOR VIII (Pegylated-Recombinant)**
**FACTOR VIII (FC Fusion Recombinant)**
**FACTOR VIII (Recombinant NOS)**
**AFSTYLA (FACTOR VIII (RECOMBINANT) SINGLE CHAIN)**
**JIVI (FACTOR VIII (RECOMBINANT) PEGYLATED-AUCL)**
**KOVALTRY (FACTOR VIII RECOMBINANT)**
**NOVOEIGHT (FACTOR VIII RECOMBINANT)**
**NUWIQ (FACTOR VIII RECOMBINANT)**
**OBIZUR (FACTOR VIII RECOMBINANT, PORCINE SEQUENCE)**
**XYNTHA (FACTOR VIII RECOMBINANT, PLASMA/ALBUMIN-FREE)**
**ELOCTATE (FACTOR VIII RECOMBINANT, FC FUSION PROTEIN)**
**ADYNOVATE (FACTOR VIII RECOMBINANT, PEGYLATED)**

### Criteria for approval of Non-Formulary/Preferred Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Treatment purpose is appropriate (MUST choose at least one):
    a. On-demand treatment and control of bleeding episode
    b. Routine prophylaxis to reduce the frequency of bleeding episodes
    c. Perioperative management of bleeding
3. Prescribed dose is less than 6000 international units per infusion (rounded to vial size)
4. Drug is not prescribed for the treatment of Von Willebrand disease.
5. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

### Exclusion Criteria:
Treatment of Von Willebrand disease

### Prescriber Restrictions:
**N/A**

### Coverage Duration:
**Approval will be for 12 months**

### FDA Indications:
**All Factor VIII Products:**
- Diagnosis of Hemophilia A
    - On-demand treatment and control of bleeding episodes
    - Routine prophylaxis to reduce the frequency of bleeding episodes
    - Perioperative management of bleeding

### Off-Label Uses:
**N/a**

## Other Clinical Consideration:

Maximum dosage: 6000 international units per infusion (rounded to vial size)

## Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/D80EF7/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/50D494/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=factor%20viii&UserSearchTerm=factor%20viii&SearchFilter=filterNone&navitem=searchGlobal