OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: Hemlibra® (emicizumab-kxwh) **Injection** ***(Medicaid)***

DRUG INFORMATION: ***Complete all information below or authorization process will be delayed.***

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

Recommended dosage:

3mg/kg by subcutaneous injection once weekly for the first 4 weeks, followed by 1.5 mg/kg once weekly.

CLINICAL CRITERIA: ***To receive a ONE (1) year approval for this drug, the following questions MUST be checked to ensure authorization process will NOT be delayed.***

1. Does member have a diagnosis of hemophilia A (congenital factor VIII deficiency) that has been confirmed by blood coagulation testing? **AND** ❑ Yes ❑ No
2. Confirmation that member has inhibitors to factor VIII? **AND** ❑ Yes ❑ No
3. Has member used routine prophylaxis to prevent or reduce the frequency of bleeding episodes? **AND** ❑ Yes ❑ No
4. Has member had ≥ 2 documented episodes of spontaneous bleeding into joints within the last 24 weeks? **OR** ❑ Yes ❑ No
5. Does member have a documented trial and failure of Immune Tolerance Induction (ITI)? ❑ Yes ❑ No

   NOTE: Hemlibra® is not used in combination with Immune Tolerance Induction (ITI)? **OR**
6. Does member have a documented trail and failure of or is currently on routine prophylaxis with a bypassing agent (e.g., NovoSeven®, Feiba®)? ❑ Yes ❑ No

Medication being provided by ***(check box below that applies)*****:**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 2/15/2018
REVISED/UPDATED: 7/1/2018