# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
# (MEDICAID)

## 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**

**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**

**(continued on next page; signature page MUST be attached to this request.)**

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***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;~~ **8/19/2018**;