

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 trial 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