

OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL 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 1-844-348-3720. 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: **Hemophilia Factors (Medical)**

DRUG INFORMATION: *Listed are the following HCPCS codes covered by Optima. Circle the appropriate HCPCS code. Incomplete information will delay authorization process.*

HCPCS Code	Description
J7180	Factor XIII (antihemophilic factor, human)
J7183	Injection, Von Willebrand factor complex
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII I.U. Alphanate®
J7187	Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 microgram
J7190	Factor VIII (antihemophilic factor [human]) per IU Alphanate®, Koate-DVI®, Monoclate-P®, Hemofil M®
J7191	Factor VIII (Antihemophilic Factor (Porcine) Hyate C-(Product has been discontinued)
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified Helixate FS®, Recombinate®, Refacto®, Kogenate FS®, Advate®
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU AlphaNine SD®, Mononine®,
J7194	Factor IX, complex, per IU Proplex T®, Bebulin VH®, Profilnine SD®
J7195	Factor IX (antihemophilic factor, recombinant) per IU BeneFIX®
J7198	Factor VIII (Autoplex T, Feiba VH)
J7199	Hemophilia clotting factor, not otherwise classified

Drug Form/Strength/Quantity: _____

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

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

CLINICAL CRITERIA: *Check the applicable diagnosis below. If information is **NOT** completed, authorization process will be delayed.*

<input type="checkbox"/> Hemophilia A – Factor VIII Disease	ICD Code: _____
<input type="checkbox"/> Hemophilia B – Factor IX Disease	ICD Code: _____
<input type="checkbox"/> von Willebrand Disease	ICD Code: _____

(signature on next page)

Medication being provided by (check applicable box below):

Location/site of drug administration: _____

NPI or DEA # of administering location: _____

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 #: _____

REVISED/UPDATED: 8/1/2017; 8/30/2017 5/25/2018