aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Hemophilia
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Request is for (specify medication name):				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
What medication(s) has member tried and failed for this diagnosis? Please specify below.				

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information		
Does member have Hemophilia A or B OR Von Willebrand disease with current serious OR life-threatening bleeds?	☐ Yes	☐ No
☐ **Hemophilia A (Inherited Factor VIII Deficiency)**		
Is there <1% of normal Factor VIII (less than 0.01 IU/mL)?	☐ Yes	☐ No
Does member have history of one or more episodes of spontaneous bleeding into joints (for example, routine bleeding prophylaxis, hemorrhage, perioperative bleeding)?	☐ Yes	☐ No
☐ **Renewal ONLY:**		
Was member screened for inhibitors since last approval?	☐ Yes	☐ No

Is an inhibitor present?	☐ Yes	☐ No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A

☐ **Hemophilia B (Inherited Factor IX Deficiency)**		
Is there < 1% of normal Factor IX (less than 0.01 IU/mL)?	☐ Yes	☐ No

Does member have history of one or more episodes of spontaneous bleeding into joints (for example, routine bleeding prophylaxis, hemorrhage, perioperative bleeding)?						☐ Yes	☐ No	
☐ **Renewal ONLY:**								
Was member screened for inhibitors since last approval?						☐ Yes	☐ No	
Is an inhibitor present?	☐ Yes	☐ No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A		
☐ **Von Willebrand Disease**								
Does member have a laboratory confirmed diagnosis?						☐ Yes	☐ No	
Does member have history of bleed (for example, prolonged wound bleed, post-surgical or dental bleed, nosebleeds, menorrhagia, excessive bruising, or family history of bleeding or bleeding disorder)?						☐ Yes	☐ No	
☐ **Novo-Seven RT (Recombinant Activated Factor VII Concentrate (Factor VIIa))**								
Member has ONE of the following FDA approved indications (check one):	☐ Acquired hemophilia ☐ Congenital Factor VII deficiency ☐ Hemophilia A or B with Inhibitors		☐ Glanzmann's thrombasthenia, when refractory to platelet transfusions, with or without antibodies to platelets					
Is treatment for hemorrhagic complications OR prevention of bleeds in surgical OR invasive procedures?						☐ Yes	☐ No	
☐ **Renewal ONLY:**								
Is an inhibitor present?	☐ Yes	☐ No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A		
☐ **Feiba (Activated Prothrombin Complex Concentrate)**								
Will Feiba be used for Hemophilia A or Hemophilia B with inhibitors?						☐ Yes	☐ No	
Will Feiba be used for the treatment of hemorrhagic complications, or prevention of bleeds, in surgical, or invasive procedures, or routine prophylaxis?						☐ Yes	☐ No	
☐ **Renewal ONLY:**								
Is an inhibitor present?	☐ Yes	☐ No	If an inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A		
☐ **Obizur**								
Will Obizur be used for acquired Hemophilia A in adults (for treatment of bleeding episodes)?	☐ Yes	☐ No	Is baseline anti-porcine Factor VIII inhibitor titer NOT > 20 Bethesda Units?			☐ Yes	☐ No	
☐ **Renewal ONLY:**								
Is inhibitor present?	☐ Yes	☐ No	If inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A		
☐ **Hemlibra**								
Will Hemlibra be used for prophylaxis of Hemophilia A with or without inhibitors?						☐ Yes	☐ No	
Is there severe disease with documentation showing <1% of normal Factor VIII (<0.01 IU/mL)?						☐ Yes	☐ No	
Is disease mild or moderate with documentation showing ≥1% of normal Factor VIII (≥0.01 IU/mL)?	☐ Yes	☐ No	Is there documentation showing at least TWO episodes of bleeding into the joints?			☐ Yes	☐ No	
Members without inhibitors have tried and failed OR have documented contraindications to TWO prophylactic factor VIII replacement products?	☐ Yes	☐ No	☐ N/A	Will medication be used for treatment of acute bleeds?		☐ Yes	☐ No	
Provider confirms that member will D/C any use of factor VIII products as prophylactic therapy while on Hemlibra (on-demand usage may be continued)?	☐ Yes	☐ No	Cumulative amount of >100 U/kg/24hrs of activated prothrombin complex concentrate has not been GIVEN for 24 HRS or more. (examples of activated prothrombin complex concentrate include Feiba, Novoseven RT)?			☐ Yes	☐ No	
☐ **Renewal ONLY:**								
Is inhibitor present?	☐ Yes	☐ No	If inhibitor is present, is there a treatment plan to address inhibitors as appropriate?	☐ Yes	☐ No	☐ N/A		
Additional information the prescribing provider feels is important to this review. Please specify below OR submit medical records.								

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.