Prior Authorization Request Form for
Emicizumab-kxwh **(Hemlibra)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the prescription being prescribed by or in consultation with a hematologist?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the indication for use routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients ages newborn and older, with hemophilia A with or without factor VIII inhibitors?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient been treated within the last 12 months for, or have current signs of, thromboembolic (TE) disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 4
4. Will the requested medication be used in combination with Immune Tolerance Induction (ITI)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[6 March 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: