NovoSeven RT

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: _______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>
*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*__________________________________ *Route of administration*________________________
*Dosing frequency*_______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Hemo - NovoSeven RT SGM – 07/2021.

Criteria Questions:

1. What is the diagnosis?
   ❑ Congenital factor VII deficiency
   ❑ Hemophilia A
   ❑ Hemophilia B
   ❑ Acquired von Willebrand syndrome
   ❑ Acquired hemophilia
   ❑ Inhibitors to factor XI
   ❑ Glanzmann's thrombasthenia
   ❑ Other ____

2. What is the ICD-10 code? _______________

3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to diagnosis section*

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
   ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hemophilia A and Hemophilia B

5. Does the patient have inhibitors? ❑ Yes ❑ No

6. At any point in time, has the patient had an inhibitor titer greater than or equal to 5 Bethesda units per milliliter (BU/mL)? ❑ Yes ❑ No

Section B: Acquired von Willebrand Syndrome

7. Have other therapies (such as desmopressin, factor VIII/von Willebrand factor [Alphanate, Humate, Wilate]) failed to control the patient's condition? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com