Clotting Factors

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:

☐ Advate (J7192)
☐ Adynovate (J7207)
☐ Afstyla (J7210)
☐ Alphanate (J7186)
☐ AlphaNine SD (J7193)
☐ Alprolix (J7201)
☐ Altuviiio
☐ ATryn (J7196)
☐ BeneFIX (J7195)
☐ Coagadex (J7175)
☐ Corifact (J7180)
☐ Eloctate (J7205)
☐ Esperoct (J7199)
☐ Feiba (J7198)
☐ Fibryga (J3490)
☐ Hemlibra
☐ Hemofil M (J7190)
☐ Humate-P (J7187)
☐ Idelvion (J7202)
☐ Ixinity (J7195)
☐ Jivi (J7208)
☐ Koate (J7190)
☐ Kogenate FS (J7192)
☐ Kovaltry (J7192)
☐ NovoSeven RT (J7189)
☐ Novoeight (J7182)
☐ Nuwiq (J7192)
☐ Profilnine (J7194)
☐ Rebinyn (J7195)
☐ Recombinate (J7192)
☐ RiaSTAP (J7178
☐ Rixubis (J7200)
☐ Sevenfact (J7212)
☐ Thrombate III (J7197)
☐ Tretten (J7181)
☐ Vonvendi (J7179)
☐ Wilate (J7183)
☐ Xyntha (J7185)

Dosage Information:

Units per dose: Directions: Number of doses required per month:

Patient's current weight: ICD10:

(for all but Advate, Adynovate, Afstyla, Alphanate, AlphaNine SD, Alprolix, Altuviiio, BeneFIX, Coagadex, Corifact, Eloctate, Esperoct, FEIBA, Hemofil M, Humate-P, Idelvion, Ixinity, Jivi, Koate, Kogenate FS, Kovaltry, Novoeight, NovoSeven RT, Nuwiq, Profilnine, Rebinyn, Recombinate, Rixubis, Sevenfact, Tretten, Vonvendi, Wilate, Xyntha, Xyntha Solofuse) Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".

☐ New start
☐ Continuation of therapy

(if continuation of therapy) Is there documentation your patient has had a beneficial response with the requested medication?

☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home ☐ Physician's Office
☐ Hospital Outpatient ☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis (check all that apply to your patient):
☐ acquired hemophilia
☐ acquired inhibitor titer to Factor VIII
☐ acquired inhibitors to factors XI or XII
☐ bleeding associated with liver disease
☐ coagulation factor X deficiency
☐ congenital fibrinogen deficiency (factor I deficiency)-afibrinogenemia
☐ congenital fibrinogen deficiency (factor I deficiency)-hypofibrinogenemia
☐ congenital fibrinogen deficiency (factor I deficiency)-dysfibrinogenemia
☐ congenital factor VII (FVII) deficiency
☐ congenital factor XIII A-subunit deficiency
☐ congenital factor XIII B-subunit deficiency
☐ congenital Factor XIII deficiency
☐ factor II deficiency
☐ factor VIII deficiency (hemophilia A)
☐ factor IX deficiency (hemophilia B)
☐ factor X deficiency
☐ factor XIII deficiency
☐ Glanzmann's thrombasthenia
☐ hemophilia A
☐ hemophilia A (congenital factor VIII deficiency)
☐ hemophilia A with inhibitors
☐ hemophilia B
☐ hemophilia B with inhibitors
☐ hereditary antithrombin deficiency (antithrombin III deficiency, AT III deficiency)
☐ hereditary Factor X deficiency
☐ inhibitors to factors XI or XII
☐ severe von Willebrand disease (VWD)
☐ mild or moderate von Willebrand disease (VWD)
☐ All other indications or diagnoses

Clinical Information
****FEIBA, SEVENFACT: These drugs requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

For AlphaNineSD, Alprolix, BeneFIX, Idelvion, Ixinity, Profilnine, Rebinyn and Rixubis only:

Is the requested product being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

(if BeneFIX, Ixinity, Rixubis) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also known as immune tolerance induction)? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg no more frequently than twice weekly for routine prophylaxis? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg intravenously no more frequently than once every 12 hours for up to 10 days per episode for on-demand treatment of and control of bleeding episodes? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg intravenously no more frequently than once every 8 hours for up to 10 days per procedure for perioperative management? ☐ Yes ☐ No

(if Alprolix, Idelvion, Rebinyn) Is the requested dosing for up to 100 IU per kg intravenously at an interval no more frequently than once weekly for routine prophylaxis? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per episode for on-demand treatment of and control of bleeding episodes? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg intravenously no more frequently than once every 24 hours for up to 10 days per procedure for perioperative management? ☐ Yes ☐ No

(if AlphaNine SD, Profilnine) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also known as immune tolerance induction)? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 50 IU per kg no more frequently than twice weekly for routine prophylaxis? ☐ Yes ☐ No

(if no) Is the requested dosing for up to 100 IU per kg intravenously no more frequently than twice daily for up to 10 days for on-demand treatment of and control of bleeding episodes and perioperative management? ☐ Yes ☐ No

For Advate, Afstyla, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, or Xyntha:

Is the requested product being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Is the requested dosing for up to 60 IU per kg intravenously no more frequently than every other day (three or four times weekly) for routine prophylaxis? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing up to 50 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per episode for on-demand treatment and control of bleeding episodes? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 60 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per procedure for perioperative management? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also known as immune tolerance induction)? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

For Adynovate, Eloctate, Esperoct, or Jivi:

Is the requested product being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Is the requested dosing for up to 100 IU per kg intravenously no more frequently than twice weekly for routine prophylaxis? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing up to 65 IU per kg intravenously no more frequently than once every 8 hours for up to 10 days per episode for on-demand treatment and control of bleeding episodes? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 65 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per procedure for perioperative management? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also known as immune tolerance induction)? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

For Alphanate, Humate-P, or Wilate only:

Is the requested product being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

(if hemophilia A) Is the requested dosing for up to 50 IU per kg intravenously no more frequently than every other day (three or four times weekly) for routine prophylaxis? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing up to 50 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per episode or procedure for on-demand treatment and control of bleeding episodes or perioperative management? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also known as immune tolerance induction)? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if vWD) What type of von Willebrand Disease (vWD) does the patient have?
☐ Type 1
☐ Type 2
☐ Type 3

(if Type 1) Is the requested medication being used for the treatment of bleeding episodes? ☐ Yes ☐ No

(if yes) Has the patient tried desmopressin injection (DDAVP injection)? ☐ Yes ☐ No

(if no) Does the patient have a severe bleeding phenotype? ☐ Yes ☐ No

(if no) Does the patient have very low vWF (von Willebrand Factor) levels? ☐ Yes ☐ No

(if no OR not for treatment of bleeding episodes) Does the patient have a history of inadequate response to injectable desmopressin in the past or has safety concerns with use of desmopressin injection (DDAVP injection)? ☐ Yes ☐ No

(if vWD) Is the requested dosing for up to 80 IU VWF:Rco (Von Willebrand Factor activity as measured with the Ristocetin cofactor assay) per kg intravenously no more frequently than once every 8 hours for up to 10 days per episode or procedure for on-demand treatment and control of bleeding episodes or perioperative management? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 40 IU VWF:Rco (Von Willebrand Factor activity as measured with the Ristocetin cofactor assay) per kg intravenously no more frequently than once every 2 days for routine prophylaxis? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if ATryn) Is ATryn being used for the prevention of perioperative or peripartum events? ☐ Yes ☐ No

(if Fibryga or RiaSTAP) Has the patient had testing showing prolonged activated partial thromboplastin time and prothrombin time at baseline, as defined by the laboratory reference values? ☐ Yes ☐ No

(if Fibryga or RiaSTAP) Has the patient had testing showing lower than normal plasma functional and antigenic fibrinogen levels at baseline, as defined by the laboratory reference values? ☐ Yes ☐ No

(**if Fibryga or RiaSTAP**) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(**if Fibryga or RiaSTAP**) Will both Fibryga and RiaSTAP be taken together at the same time? ☐ Yes ☐ No

(If yes) Please provide the clinical rationale for concurrent use:

(if Coagadex)

For which of the following is this drug being used?

☐ Peri-operative management of bleeding in individuals with mild, moderate, or severe hereditary Factor X deficiency
☐ Routine prophylaxis to reduce the frequency of bleeding episodes
☐ Treatment of bleeding episodes
☐ Other

(if other) Please provide clinical rationale for the use of this drug in your patient.

For Altuviiio only:

Is Altuviiio being used in at least one of the following scenarios: 1) Routine prophylaxis; or 2) On-demand treatment and control of bleeding episodes; or 3) Perioperative management of bleeding?

☐ Routine prophylaxis
☐ On-demand treatment and control of bleeding episodes
☐ Perioperative management of bleeding
☐ None of the above scenarios apply

Is the medication being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Is the patient currently receiving Altuviiio or has received Altuviiio in the past? ☐ Yes ☐ No

(if no) Has the patient received Factor VIII therapy in the past? ☐ Yes ☐ No

(if yes) Has Factor VIII inhibitor testing been performed within the past 30 days? ☐ Yes ☐ No

(if yes) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 1.0 Bethesda units/mL? ☐ Yes ☐ No

(if currently receiving or has received Altuviiio in the past) Has Factor VIII inhibitor testing been performed within the past 365 days? ☐ Yes ☐ No

(if yes) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 1.0 Bethesda units/mL? ☐ Yes ☐ No

(if no Factor VIII inhibitor testing in past 365 days OR no positive test for Factor VIII inhibitors 1.0 Bethesda units/ml or more) According to the prescriber, does the patient have clinical manifestations suggesting the presence of Factor VIII inhibitors? Please Note: Inhibitors may be present if bleeding is not well controlled, there is decreased responsiveness to Factor VIII therapy, and/or if expected Factor VIII activity plasma levels are not achieved. ☐ Yes ☐ No

If Hemofil M or Koate:

Is the requested product being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Is the requested dosing for up to 50 IU per kg intravenously no more frequently than every other day (three or four times weekly) for routine prophylaxis? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing up to 50 IU per kg intravenously no more frequently than once every 6 hours for up to 10 days per episode or procedure for on-demand treatment and control of bleeding episodes or perioperative management? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if no) Is the requested dosing for up to 200 IU per kg intravenously no more frequently than once daily for immune tolerance therapy (also knowns as immune tolerance induction)? Please be sure to provide the patient's weight in kg. ☐ Yes ☐ No

(if Vonvendi)
For which of the following is this drug being used?
☐ On demand treatment and control of bleeding episodes
☐ Peri-operative management
☐ Routine prophylaxis
☐ None of the above

(if Coagadex, Corifact, Tretten, Vonvendi) Is the requested medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Hemlibra) Is there documentation that your patient has one of the following?
☐ factor XIII inhibitors
☐ mild or moderate hemophilia (defined as factor VIII level of 1% to less than 40%)
☐ severe hemophilia defined as pre-treatment factor VIII level less than 1%
☐ none of the above
(if mild/moderate) Which of the following applies to your patient? Please provide documentation
☐ 1 or more episodes of bleeding into the central nervous system or other serious, life-threatening bleed
☐ 1 or more episodes of bleeding into large joint (ankles, knees, hips, elbows, shoulders) and age 3 years or younger
☐ 2 or more episodes of bleeding into large joints (ankles, knees, hips, elbows, shoulders)
☐ presence of joint disease documented by physical examination and plain radiographs of the affected joints
☐ none of the above

(if Hemlibra) Is Hemlibra being used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ☐ Yes ☐ No

(if no) Please specify the use for which Hemlibra is being prescribed.

(**if NovoSeven RT**) (if Glanzmann's thrombasthenia) Is the patient refractory to platelet transfusions? ☐ Yes ☐ No

NovoSeven RT or Sevenfact:

(if NovoSeven RT and Glanzmann's thrombasthenia) Is the requested medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Sevenfact) Is the requested medication being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

(if Hemophilia A with inhibitors) (If Hemophilia A with inhibitors) Is documentation being provided that the patient has a positive inhibitor titer greater than or equal to 5 Bethesda Units? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No
(if no) Is documentation being provided that the patient has a history of an inhibitor with anamnestic response to Factor VIII replacement therapy, which, according to the prescriber, precludes the use of Factor VIII replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has a history of an inhibitor with refractory hemostatic response to increased Factor VIII dosing, which, according to the prescriber, precludes the use of Factor VIII replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

((if Hemophilia B with inhibitors) Is documentation being provided that the patient has a positive inhibitor titer greater than or equal to 5 Bethesda Units? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has a history of an inhibitor with anamnestic response to Factor IX replacement therapy, which, according to the prescriber, precludes the use of Factor IX replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has a history of an inhibitor with refractory hemostatic response to increased Factor IX dosing, which, according to the prescriber, precludes the use of Factor IX replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if NovoSeven RT and hemophilia [acquired, A/B with inhibitors]) Is the requested medication being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

(if Thrombate III) Is Thrombate III being used to treat or prevent pulmonary or deep vein embolisms (PE, DVT)? ☐ Yes ☐ No

If yes, please include the most recent clinical notes.

(if Thrombate III) Is your patient undergoing a surgical or obstetrical procedure? ☐ Yes ☐ No

For FEIBA only:

(if Hemophilia A with inhibitors):

Is documentation being provided that the patient has a positive inhibitor titer greater than or equal to 5 Bethesda Units? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided that the patient has a history of an inhibitor with anamnestic response to Factor VIII replacement therapy, which, according to the prescriber, precludes the use of Factor VIII replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided that the patient has a history of an inhibitor with refractory hemostatic response to increased Factor VIII dosing, which, according to the prescriber, precludes the use of Factor VIII replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if Hemophilia B with inhibitors):

Is documentation being provided that the patient has a positive inhibitor titer greater than or equal to 5 Bethesda Units? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided that the patient has a history of an inhibitor with anamnestic response to Factor IX replacement therapy, which, according to the prescriber, precludes the use of Factor IX replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided that the patient has a history of an inhibitor with refractory hemostatic response to increased Factor IX dosing, which, according to the prescriber, precludes the use of Factor IX replacement to treat bleeding episodes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if Hemophilia A OR Hemophilia B with Inhibitors):

Is the requested medication being prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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