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 D (J7193)
☐ Alprolix (J7201)
☐ 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 (J7199)
☐ Koate (J7190)
☐ Kogenate FS (J7192)
☐ Kovaltry (J7192)
☐ Mononine (J7193)
☐ NovoSeven RT (J7189)
☐ Novoeight (J7182)
☐ Nuwiq (J7192)
☐ Obizur (J7188)
☐ 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:

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 (1640 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):

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 A
☐ acquired inhibitor titer to Factor VIII
☐ acquired inhibitors to factors XI or XII
☐ coagulation factor X deficiency
☐ congenital fibrinogen deficiency (afibrinogenemia and hypofibrinogenemia)
☐ congenital factor VII (FVII) deficiency
☐ congenital factor XIII A-subunit deficiency
☐ factor II deficiency

☐ factor VIII deficiency (hemophilia A)
☐ factor IX deficiency (hemophilia B)
☐ factor X deficiency
☐ factor XIII deficiency
☐ Glanzmann's thrombasthenia with refractoriness to platelet transfusions
☐ 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)
☐ inhibitors to factors XI or XII
☐ severe von Willebrand disease (VWD)
☐ mild or moderate von Willebrand disease (VWD)
☐ Other (please specify):

Clinical Information

****FEIBA, Hemlibra, NovoSeven RT, Obizur, SEVENFACT and Tretten: These drugs requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

(if Advate, Adynovate, Afstyla, Alprolix, Coagadex, Eloctate, Esperoct, Hemofil M, Idelvion, Jivi, Koate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Rixubis, Xyntha) For which of the following is the requested drug being used?
☐ On-demand treatment and control of bleeding episodes
☐ Peri-operative management of bleeding
☐ Routine prophylaxis to reduce the frequency of bleeding episodes
☐ Other

(if peri-operative) What is/was the date of surgery? _____
(if prophylaxis) What is the frequency of bleeding episodes? _____
(if other) Why is this drug being prescribed? _____

(**if Coagadex**) (if surgery) Is your patient considered to have mild (FX:C measurement of 6–10%) or moderate disease (FX:C measurement of 1-5%)? Yes ☐ No ☐
(**if Alphanate with vWD**) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following:
A. Concentrated intranasal desmopressin (Stimate)
B. Parenteral desmopressin (DDAVP injection)? Yes ☐ No ☐
(if Alphanate) For which of the following is Alphanate being used?
☐ treatment of current active bleed
☐ prevention of excessive bleeding during and/or following surgery
☐ routine prophylaxis
☐ as needed dosing for future bleeds
☐ other
(if as needed dosing) What is the approximate number of bleeds requiring factor treatment per month? _____
(if surgery) What is the date of the surgery/procedure? _____
(if surgery and type III vWD) Is your patient undergoing major surgery?
☐ yes/unknown
☐ no
(if other) Please provide clinical rationale for the use of Alphanate in your patient. _____

(**if Alphanine SD, Mononine**) For which of the following is the requested drug being used?
☐ for prevention or control of bleeding
☐ other
(if prevention or control of bleeding) What is the frequency of bleeding episodes? _____
(if other) Why is this drug being prescribed? _____

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

(**if BeneFIX, Ixinity**) For which of the following is the requested drug being used?
☐ Prevention or control of bleeding
☐ Peri-operative management of bleeding
☐ other
(if peri-operative) What is/was the date of surgery? _____
(if prevention or control of bleeding) What is the frequency of bleeding episodes? _____
(if other) Why is this drug being prescribed? _____

(**if Fibryga or RiaSTAP**) Is this drug being used to treat acute bleeding episodes? Yes ☐ No ☐
(if no) What is the diagnosis related to use?

(**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 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 ☐ Unknown ☐

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

(**if Humate-P and type I or II vWD**) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following:
A. Concentrated intranasal desmopressin (Stimate)
B. Parenteral desmopressin (DDAVP injection)? Yes ☐ No ☐

(**if Humate-P, Obizur, Rebinyn**)
For which of the following is the drug requested being used?
☐ treatment of current active bleed
☐ prevention of excessive bleeding during and/or following surgery
☐ routine prophylaxis
☐ as needed dosing for future bleeds
☐ other

(if surgery) What is the date of surgery? _____
(if as needed dosing) What is the approximate number of bleeds requiring factor treatment per month? _____
(if other) Please provide clinical rationale for the use of this drug in your patient. _____

(**if Jivi**) Has your patient been previously treated for this diagnosis? Examples include Advate, Adynovate, Afstyla, Alphanate, Eloctate, Feiba, Helixate FS, Hemlibra, Hemofil M, Humate-P, Koate, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate, Xyntha. Yes ☐ No ☐

(**if NovoSeven RT**) (if Glanzmann's thrombasthenia) Did your patient fail to respond to platelet transfusions? Yes ☐ No ☐

(**if Obizur**) (if acquired hemophilia) Has there been documentation provided of autoimmune inhibitory antibodies to human factor VIII? Yes ☐ No ☐

(if Profilnine) For which of the following is this drug being used?
☐ control of bleeding
☐ prevention of bleeding
☐ other

(if prevention or control of bleeding) What is the frequency of bleeding episodes? _____
(if other) Why is this drug being prescribed? _____

<u>Feiba, NovoSeven RT or Sevenfact for hemophilia A/B:</u>
Is the drug requested being prescribed by, or in consultation with, a hematologist? Yes ☐ No ☐
(**if Hemophilia A**) Does the patient have a positive inhibitor titer of at least 5 Bethesda Units? Yes ☐ No ☐
(if no to previous question) Does the patient have a history of anamnestic response to Factor VIII replacement therapy, which precludes the use of Factor VIII replacement to treat bleeding episodes? Yes ☐ No ☐
(if no to previous question) Does the patient have a history of refractory response to increased Factor VIII dosing, which precludes the use of Factor VIII replacement to treat bleeding episodes? Yes ☐ No ☐

(**if Hemophilia B**) Does the patient have a positive inhibitor titer of at least 5 Bethesda Units? Yes ☐ No ☐
(if no to previous question) Does the patient have a history of anamnestic response to Factor IX replacement therapy, which precludes the use of Factor IX replacement to treat bleeding episodes? Yes ☐ No ☐
(if no to previous question) Does the patient have a history of refractory response to increased Factor IX dosing, which precludes the use of Factor IX replacement to treat bleeding episodes? 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 ☐

(**if Tretten**) Is this drug being used for routine prophylaxis of bleeding? Yes ☐ No ☐
(if no) What is the diagnosis related to use? _____

(**if Tretten**) Does your patient have documented A-subunit deficiency? Yes ☐ No ☐
If yes, please include documentation.

(**if Vonvendi, Wilate**) For which of the following is Vonvendi being used?
☐ treatment of current active bleed or as needed dosing for future bleeds
☐ routine prophylaxis
☐ management of bleeding associated with surgery (including prevention of excessive bleeding)
☐ other
(if surgery) What is the date of surgery? _____
(if other) Please provide clinical rationale for the use of Vonvendi in your patient. _____

(**if Wilate and mild to moderate vWD**) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following:
A. Concentrated intranasal desmopressin (Stimate)
B. Parenteral desmopressin (DDAVP injection)? Yes ☐ No ☐

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V020321