GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Antihemophilia Agents** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Drug #2 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Is the medication being prescribed by a hematologist or hemophilia treatment center practitioner?	☐Yes	☐No

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL REQUESTS

☐**Request is for HEMLIBRA (emicizumab):**
- ☐Has a diagnosis of severe hemophilia A
- ☐Has a diagnosis of severe hemophilia A with inhibitors
- ☐Has a diagnosis of hemophilia A and a history of at least 1 spontaneous joint bleed or other serious bleeding event

☐**Request is for a BYPASSING AGENT (eg, FEIBA NF, NovoSeven, Sevenfact):**
- ☐**For routine prophylaxis:**
  - ☐Has hemophilia A with inhibitors **AND** *(check all that apply)*:
    - ☐Failed to achieve clinical goals with Hemlibra
    - ☐Has a medical reason why Hemlibra cannot be used
    - ☐Has been using the requested bypassing agent for routine prophylaxis within the past 90 days
  - ☐Has hemophilia B with inhibitors
- ☐**For use other than routine prophylaxis (e.g., episodic/on-demand treatment, intermittent/periodic prophylaxis):**
  - ☐Has hemophilia A with inhibitors OR has hemophilia B with inhibitors

☐**Request is for a non-preferred FACTOR VIII, FACTOR IX, or vWF:**
- ☐Has been using the requested product within the past 90 days AND has a medical reason to continue using the requested product
- ☐Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred FVIII, FIX, or FVIII/vWF products with the same half-life (standard v. extended half-life). *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

RENEWAL REQUESTS

☐Experienced a positive clinical response since starting the requested medication

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

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Prescriber Signature:	**Date**: