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 1/8/2024)*

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:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:	
Directions:	Quantity:	Refills:
Drug #2 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Is the medication 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

1. Request is for HEMLIBRA (emicizumab):

☐Has a diagnosis of severe congenital hemophilia A

☐Has a diagnosis of congenital hemophilia A with inhibitors

☐Has a diagnosis of congenital hemophilia A and a history of at least 1 spontaneous joint bleed or other serious bleeding event

2. Request is for a BYPASSING AGENT (eg, FEIBA NF, NovoSeven, Sevenfact):

☐Has hemophilia A with inhibitors AND:

☐Is using the requested medication for episodic/on-demand treatment OR intermittent/periodic prophylaxis

☐Is using the requested medication for routine prophylaxis AND:

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☐ Failed to achieve clinical goals with Hemlibra (emicizumab)

☐ Has a medical reason why Hemlibra (emicizumab) cannot be used

☐ Has been using the requested bypassing agent for routine prophylaxis within the past 90 days

☐ Has hemophilia B with inhibitors

☐ Has acquired hemophilia

☐ Has congenital factor VII deficiency

☐ Has Glanzmann's thrombasthenia

3. Request is for a non-preferred FACTOR VIII, FACTOR IX, or VWF:

☐ Both of the following:

☐ Has been using the requested medication within the past 90 days

☐ Has a medical reason to continue using the requested medication

☐ Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred FVIII, FIX, or FVIII/VWF medications with the same half-life (standard v. extended half-life), if applicable. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

☐ Has a diagnosis for which no preferred Antihemophilia Agents are appropriate. *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.

Prescriber Signature:	**Date**: