Bright HealthCare™

Hemophilia Authorization Requests: Supplemental Clinical Form

This form pertains to the following products:

Advate	Feiba	Nuwiq
Adynovate*	Hemlibra	Obizur
Afstyla	Hemofil M	Profilnine
Alphanate	Humate-P	Rebinyn*
AlphaNine SD	Idelvion*	Recombinate
Alprolix *	Ixinity	Rixubis
BeneFIX	Koate-DVI	Sevenfact
Coagadex	Kogenate FS	Tretten
Corifact	Kovaltry	Vonvendi
Eloctate*	Novoeight	Wilate
Esperoct*	NovoSeven RT	Xyntha

**Step therapy requirements and additional clinical parameters may need to be met prior to obtaining these products.*

Please complete this form in addition to the Prior Authorization Request Form.
Please attach relevant progress notes and/or bleeding diaries.
Fax the completed form and relevant clinical information to the same fax number as noted on the Prior Authorization Request Form.
Note: All lab results must be submitted via fax.

Patient Information

First Name	Last Name
Member ID	Patient DOB

Provider Information

Prescriber Name	Phone	Fax

Primary Diagnosis

- ☐ Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- ☐ Acquired Hemophilia A (Aquired Factor VIII Deficiency)
- ☐ Hemophilia B (Congenital Factor IX Deficiency)
- ☐ von Willebrand Disease
- ☐ Congenital Factor XIII Deficiency
- ☐ Congenital Factor XIII A-subunit Deficiency
- ☐ Hereditary Factor X Deficiency
- ☐ Congenital Factor VII Deficiency
- ☐ Glanzmann's Thrombasthenia

Patient Inventory (Medication on Hand)

Total Number of Doses on Hand	Total Units on Hand (IU)	Date Verified

Clinical Information

Name of Treating Facility

Treatment status	Product Name
☐ Treatment-naïve ☐ Treatment-experienced	

Was the patient on a different factor product previously?
- ☐ Yes
- ☐ No

If yes, which product and reason for change:

Clinical Information (continued)

Member's Height	Member's Weight	Severity of Disease ☐ Mild (6% to 25% factor level) ☐ Moderate (1% to 5% factor level) ☐ Severe (< 1% factor level)
Dose (IU)	Number of Doses Requested	Total Dose Requested (IU)

Dosing Instructions	Retrospective request? ☐ Yes ☐ No
Type of Use (Check all that apply) ☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure *Date of Procedure:*_____ ☐ Surgical Prophylaxis *Date of Procedure*:_____	Place of Administration: ☐ Home infusion ☐ Outpatient Hemophilia Treatment Center (HTC) ☐ Outpatient Hospital ☐ Provider's office ☐ Self-administration

Number and Location of bleeds in the past 12 months:

Does the patient have a diagnosis confirmed by blood coagulation testing?

- ☐ Yes
- ☐ No

Please provide the following information regarding factor levels

- ☐ Factor VIII for Hemophilia A
- ☐ Factor IX for Hemophilia B
- ☐ Factor X for Hereditary Factor X Deficiency
- ☐ Factor XIII for Congenital Factor XIII or Factor XXIII A-subunit Deficiencies
- ☐ VW Factor for von Willebrand Disease

a. Baseline Factor Level _____

b. Date of Factor Level_____

c. Desired (Target) Factor Level_____

Does the patient have inhibitors to factor products?

- ☐ Yes
- ☐ No

If so, are documentations of inhibitor tests attached? (e.g., Bethesda inhibitor assay)

- ☐ Yes
- ☐ No

For minimally treated patients (< 50 exposure days to factor products) previously receiving a different factor product, how often will inhibitor testing be performed?

Clinical Information (continued)

Was a pharmacokinetics (PK) test performed for this patient?

- ☐ Yes
- ☐ No

If so, are PK testing results attached?

- ☐ Yes
- ☐ No

If patient has a diagnosis of Glanzmann's Thrombasthenia, has the patient tried platelet transfusions?

- ☐ Yes
- ☐ No

If yes, date of the trial and patient response: _____

If the patient has a diagnosis of von Willebrand Disease (VWD), has the patient tried desmopressin?

- ☐ Yes
- ☐ No

If no, is the patient contraindicated to desmopressin?

- ☐ Yes
- ☐ No

If yes, what is the reason for contraindication:_____

For acute bleeding episodes, please provide the following additional information:

Location of Bleed	Type of Bleed	Start Date of Bleed:	End Date of Bleed:
	☐ Minor ☐ Moderate ☐ Major		

Number of Doses Used	Dose (IU)	Total Amount Used (IU)