Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

If the patient's diagnosis is congenital hemophilia A with or without factor VIII (FVIII) inhibitors, please provide the following information:

1. Is the requested medication Hemlibra (emicizumab)? ☐ Yes ☐ No
2. How often will the medication be dosed? _____
3. Was the patient diagnosis of hemophilia A (congenital FVIII deficiency), established by or in consultation with a hematologist? ☐ Yes ☐ No
4. Does the patient have high titer FVIII inhibitors? ☐ Yes ☐ No
   If so, please provide documentation of a history of high anti-FVIII titer (> 5 Bethesda units).
5. Does the patient have hemophilia A WITHOUT FVIII inhibitors (also referred to "with low or no titer FVIII inhibitors")? ☐ Yes ☐ No
   If yes, which of the following apply:
   - ☐ A diagnosis of hemophilia A (congenital FVIII deficiency), established by or in consultation with a hematologist.
   - ☐ Documentation that the patient is WITHOUT FVIII inhibitors, confirmed by testing and no FVIII inhibitors (< 0.6 Bethesda units) or low anti-FVIII titer (< 5 Bethesda units).
   - ☐Patient is not able to administer Factor VIII product for a medical reason, i.e., no venous access (as attested by the prescribing physician)
   - ☐ None of the above apply

1. Is the requested medication Adynovate, Eloctate, Esperoct, Jivi, Advate, Afstyla, Helixate FS, Kogenate FS, Kovaltry, NovoEight, Nuwiq, Recombinate, Xyntha, Alphanate, Humate P, Wilate, Hemophil M or Koate DVI? ☐ Yes ☐ No
2. Was the patient diagnosis of hemophilia A (congenital FVIII deficiency), established by or in consultation with a hematologist? ☐ Yes ☐ No
3. Please indicate the severity of the patient's disease:
   - ☐ Mild
   - ☐ Moderate
   - ☐ Severe
4. Has the patient had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin? ☐ Yes ☐ No
5. Has the patient previously received treatment for hemophilia A with a factor VIII product? ☐ Yes ☐ No
6. What is the patient's weight? _____
7. What is the patient's age? _____
8. Was a patient inhibitor status test completed within the last 12 months? ☐ Yes ☐ No
9. Please indicate the intended use of the requested medication:

   ☐on-demand

   NOTE: If on-demand, there must be documentation of the severity (minor/moderate/severe) of bleeding episodes, specific number of doses and frequency requested per month and rationale for dosing.

   ☐Perioperative use

   NOTE: If perioperative use, there must be documentation that indicates the date and type of surgery that will be performed (Minor/Moderate or Major), dose and frequency requested, and rationale for dosing.

   ☐Prophylaxis

   NOTE: If primary prophylaxis, there must be documentation that member has severe hemophilia A (Factor VIII levels less than 1% of normal (< 1 IU/dL or 0.01 IU/ml)).

   NOTE: If secondary prophylaxis, there must be documentation that member has hemophilia A (regardless of normal factor levels) and has documented history of two (2) or more spontaneous bleeding into the joints.

1. Is the requested medication Obizur? ☐ Yes ☐ No
2. Was the patient diagnosis of hemophilia A (congenital FVIII deficiency), established by or in consultation with a hematologist? ☐ Yes ☐ No
3. Is the patient's baseline anti- porcine factor VIII inhibitor titer less than or equal to 20 BU? ☐ Yes ☐ No

If the patient's diagnosis is congenital hemophilia B, p**lease provide the following information:**

1. Is the requested medication Alprolix, Idelvion, Rebinyn, Benfix, Ixinity, Rixubus Alphanine, Mononine, or Profilnine? ☐ Yes ☐ No
2. Was the diagnosis of hemophilia B established by or in consultation with a hematologist? ☐ Yes ☐ No
3. What is the patient's weight? _____
4. What is the patient's age? _____
5. Was a patient inhibitor status test completed within the last 12 months? ☐ Yes ☐ No
6. Please indicate the intended use of the requested medication:

   ☐on-demand

   NOTE: If on-demand or prevention of bleeding, there must be documentation of the severity (minor/moderate/severe) of bleeding episodes, specific number of doses and frequency requested per month and rationale for dosing.

   ☐Perioperative use

   NOTE: If for perioperative use, there must be documentation that indicates the date and type of surgery that will be performed (Minor/Moderate or Major), dose and frequency requested and rationale.

   ☐Prophylaxis

   NOTE: If primary prophylaxis (provide documentation that Factor IX levels are < 1 IU/dL (less than 1% of normal factor or 0.01 IU/ml), consistent with severe hemophilia.

   NOTE: If secondary prophylaxis, provide documentation of hemophilia B (regardless of normal factor levels) and has documented history of two (2) or more spontaneous bleeding into the joints.
7. Does the patient have bleeding due to low levels of liver dependent coagulation? ☐ Yes ☐ No

If the patient's diagnosis is von Willebrand disease (vWD)., p**lease provide the following information:**

1. Is the requested medication Vonvendi? ☐ Yes ☐ No
2. Please indicate which of the following apply:

   The patient has a diagnosis of vWD that is established by or in consultation with a hematologist, as follows:
   ☐ Severe (Type 2B or Type 3) vWD
   ☐ Mild to Moderate (Type 1, 2A, 2M, or 2N) vWD, with clinical documentation that treatment with desmopressin that was ineffective, not tolerated, or is contraindicated, or unless one of the following clinical reasons:
   - ☐ Age < 2 years
   - ☐ Pregnancy
   - ☐ Fluid/electrolyte imbalance
   - ☐ High risk for cardiovascular or cerebrovascular disease (especially the elderly)
   - ☐ Predisposition to thrombus formation
   - ☐ Trauma requiring surgery
   - ☐ Life-threatening bleed

☐Contraindication or intolerance to desmopressin
☐ Acquired von Willebrand Syndrome

3. Will the Vonvendi is be used for routine prophylactic treatment of spontaneous bleeding? ☐ Yes ☐ No

4. Is the requested medication Alphanate, Humate-P or Wilate? ☐ Yes ☐ No

1. Please indicate which of the following apply:
   The patient has a diagnosis of vWD that is established by or in consultation with a hematologist, as follows:
   - ☐ Severe (Type 2B or Type 3) vWD
   - ☐ Mild to Moderate (Type 1, 2A, 2M, or 2N) vWD, with clinical documentation that treatment with desmopressin and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin
   - ☐ The patient does not have a diagnosis of vWD

2. If the requested medication is Humate-P or Wilate:
   a. Is the treatment for on-demand treatment of spontaneous or trauma induced bleed? ☐ Yes ☐ No
      If yes, please provide/indicate the following:
      ☐ documentation of the severity (minor/moderate/severe) of bleeding episodes, specific number of doses and frequency requested per month and rationale for dosing based on patient utilization and/or pharmacokinetic assay testing.
   b. Is the treatment for perioperative management of bleeding during major or minor surgical procedures in patients with vWD?
      If yes, please provide the following:
      If the request is for Alphanate, does the member have type 3vWD? ☐ Yes ☐ No
      If the answer is no, please provide documentation

      ☐ Please submit documentation that indicates the date and type of surgery that will be performed (Minor/Moderate or Major), specific number of doses and frequency, and rationale based on patient utilization and/or pharmacokinetic assay testing.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date