ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:
Name of office contact:	Contact's phone number:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:		
Apt #: / City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	NPI:
Street address:		
Suite #: / City/state/zip:		
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: ☐ Hemlibra	☐ Factor (name):	J-code:	Weight: lbs/kg
Strength/vial size:		# of vials:	NDC#:
Strength/vial size:		# of vials:	NDC#:
Administration date: (to)	(from)	Dispense date:	
DX code (required):		Diagnosis (submit documentation):	
Directions:		Total quantity requested:	Duration:

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
NPI#:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

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

1. For a NON-FACTOR replacement agent:

For hemophilia A (check all that apply):
- ☐ Has diagnosis of severe congenital hemophilia A
- ☐ Has diagnosis of congenital hemophilia A with inhibitors
- ☐ Has diagnosis of congenital hemophilia A and a history of at least one spontaneous episode of bleeding into a joint or other serious bleeding event
- ☐ Has diagnosis of acquired hemophilia A

For hemophilia B (check all that apply):
- ☐ Has diagnosis of severe congenital hemophilia B
- ☐ Has diagnosis of congenital hemophilia B with inhibitors
- ☐ Has diagnosis of congenital hemophilia B and a history of at least one spontaneous episode of bleeding into a joint or other serious bleeding event

2. For a non-preferred NON-FACTOR replacement agent:

☐ Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred non-factor replacement Antihemophilia Agents approved or medically accepted for the beneficiary's diagnosis. Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred drugs in this class.

List medication(s) tried: _____

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

3. For a BYPASSING AGENT (e.g., FEIBA NF, NovoSeven):

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
- ☐ Has acquired hemophilia
- ☐ Has congenital factor VII deficiency
- ☐ Has Glanzmann's thrombasthenia

For use other than routine prophylaxis (e.g., episodic/on-demand treatment, intermittent/periodic prophylaxis):
- ☐ Has hemophilia A with inhibitors

4. 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), if applicable. Refer to **https://papdl.com/preferred drug-list** for a list of preferred and non-preferred drugs in this class.

List medication(s) tried: _____

- ☐ 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

5. Experienced a positive clinical response since starting the requested medication: ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: