Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Factor IX Agents (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Factor IX Agents (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Is the requested therapy prescribed by a hematology specialist? Y N

   [If no, no further questions.]

2. Does the patient meet both of the following: A) diagnosis of hemophilia B, and B) current serious or life-threatening bleed (central nervous system bleed, ocular bleeding, bleeding into hip, intra-abdominal bleeding, bleeding into neck or throat, iliopsoas bleeding, significant bleeding from trauma)? Y N

   [If yes, no further questions.]

3. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

[If yes, skip to question 7.]

4. Does the patient have a diagnosis of Hemophilia B (Factor IX deficiency)? Y N

   [If no, no further questions.]

5. Does the patient meet any of the following: A) less than 1 percent of normal factor IX (less than 0.01 IU/ml), or B) documented history of 1 or more episodes of spontaneous bleeding into joints? Y N

   [If no, no further questions.]

6. Is therapy requested for perioperative bleeding, hemorrhage, or routine bleeding prophylaxis? Y N

   [No further questions.]

7. Has the patient been screened for inhibitors since the last approval? Y N

   [If no, no further questions.]

8. Are inhibitors present? Y N

   [If no, no further questions.]

9. Does the patient have a treatment plan to address inhibitors as appropriate, such as changing product, monitoring if transient inhibitor or low responder, OR if the inhibitor is greater than 5 Bethesda units, increase dose and/or frequency for Immune Tolerance Induction, change to bypassing agent, and/or, addition of immunomodulator(s)? Y N

   Note: May attach documentation of treatment plan to address inhibitors.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**