



Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries and **fax to 1-888-656-0841**. All lab results must be faxed in.

This request form pertains to the following products:

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

I. Demographic Information

Patient Information		
First Name	Last Name	Patient Gender
Patient DOB	Patient Phone #	Alternative Phone #
Patient Address:		
City	State	Zip code
Provider Information		
Prescriber Name	Contact Name	Contact Phone #
NPI	Fax #	
Prescriber Address:		
City	State	Zip code

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Rendering Provider (Dispensing Pharmacy) Information

Pharmacy Name	NPI	NABP
Contact Name	Phone #	Fax #

Insurance Information

Policy Holder Name	ID# of Insurance Card
Name of Insurance Company	Group #

Primary Diagnosis

- Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- Acquired Hemophilia A (Acquired 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

ICD 10 Code

Patient Inventory (Medication on Hand)

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

Name of Treating Facility

Treatment status <input type="checkbox"/> Treatment-naïve <input type="checkbox"/> Treatment-experienced		Product Name	
Was the patient on a different factor product previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which product and reason for product switching: _____ _____			
Member's Height	Member's Weight	Severity of Disease <input type="checkbox"/> Mild (6% to 25% factor level) <input type="checkbox"/> Moderate (1% to 5% factor level) <input type="checkbox"/> Severe (< 1% factor level)	
Dose (IU)	Number of Doses Requested	Total Dose Requested (IU)	
Dosing Instructions		Retrospective request? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Use (Check all that applies) <input type="checkbox"/> Episodic <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Acute Bleeding Episode <input type="checkbox"/> Dental Procedure Date of Procedure: _____ <input type="checkbox"/> Surgical Prophylaxis Date of Procedure: _____		Place of Administration: <input type="checkbox"/> Home infusion <input type="checkbox"/> Outpatient Hemophilia Treatment Center (HTC) <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Self-administration	
Number and Location of bleeds in the past 12 months:			
Does the patient have a diagnosis confirmed by blood coagulation testing? <input type="checkbox"/> Yes <input type="checkbox"/> 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

Has the patient previously received Immune Tolerance Induction (ITI)?

- Yes
- No

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

Did the patient experience at least two documented episodes of spontaneous bleeding into the joints?

- 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?

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 <input type="checkbox"/> Minor <input type="checkbox"/> Moderate <input type="checkbox"/> Major	Start Date of Bleed:	End Date of Bleed:
Number of Doses Used	Dose (IU)	Total Amount Used (IU)	

To view current hemophilia policies and the Hemophilia Product Prior Authorization Form, please visit AlabamaBlue.com/providers/policies.