SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Hemlibra® (emicizumab-kxwh) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug and Billing Provider Information

❑ ***Physician billing*** **(HCPCS code:**_____**)** ❑ ***Pharmacy billing*** **(Provide NDC(s) below)**

Fill Date:_____ **If pharmacy billing, Pharmacist Name :**_____

SoonerCare Provider ID:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Clinical Information

1. Does patient have congenital Hemophilia A? Yes ☐ No ☐
2. **For members with inhibitors:**
   a. What is the titer level in Bethesda units (BU)? _____ Date taken: _____
   b. Has member failed immune tolerance induction therapy (ITI)? Yes ☐ No ☐
      i. If yes, then list dates of ITI: _____ What was used during ITI [product(s), dose(s), & regimen(s)]?_____
      _____
      ii. If no, then is the patient a good candidate for ITI? Yes ☐ No ☐
   c. Is member receiving bypassing agent(s) (Feiba and/or NovoSeven) as prophylaxis to prevent bleeding episodes or to treat bleeding episodes? Yes ☐ No ☐
      i. If yes please list:
      Product:_____ Dose:_____ Regimen:_____
      Product:_____ Dose:_____ Regimen:_____
   d. Will member be using Feiba for breakthrough bleeding? Yes ☐ No ☐
      i. If yes, then has member and/or caregiver been counseled about the risks of using Feiba while taking Hemlibra? Yes ☐ No ☐
   e. Has member been counseled to call prescriber anytime any bypassing agent is used? Yes ☐ No ☐
3. **For members without inhibitors:**
   a. Member's current treatment:
      Product: _____ Dose:_____ Regimen:_____
   b. Please list clinical reasoning for changing therapy (breakthrough bleeding, hospitalizations, half-life studies, etc.):_____
   c. Is the member and/or caregiver aware of treatment plan for breakthrough bleeding:? Yes ☐ No ☐
4. Member's current annual bleeding rate:_____
5. Location where first dose will be given:_____
6. Hemlibra® dose prescribed: _____ Regimen: _____
   NDCs: _____-____-__ vials per dose:_____ _____-____-__ vials per dose:_____
   _____-____-__ vials per dose:_____ _____-____-__ vials per dose:_____
7. Member's weight: _____ kg Date weight taken:_____

Prescriber Signature: _____ **Date:** _____

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary.
Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OHCA Approved – 06/12/2019