

Factor Replacement Products Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____
Pharmacy NPI: _____ **Pharmacy Phone:** _____ **Pharmacy Fax:** _____
Pharmacy Name: _____ **Pharmacist Name:** _____
Prescriber NPI: _____ **Prescriber Name:** _____
Specialty: _____ **Prescriber Phone:** _____ **Prescriber Fax:** _____
Fill Date: _____

Clinical Information

1. Diagnosis (ICD-10): _____ Inhibitor : Yes: ___ No: ___
2. Factor Replacement Product: _____
3. NDCs to be potentially used throughout year (to be completed by the dispensing pharmacy):

_____-_____-_____-	_____-_____-_____-	_____-_____-_____-	_____-_____-_____-
_____-_____-_____-	_____-_____-_____-	_____-_____-_____-	_____-_____-_____-
_____-_____-_____-	_____-_____-_____-	_____-_____-_____-	_____-_____-_____-
4. Estimate total units to be used per year: _____
5. For members requesting an extended half-life factor product or Obizur® a patient-specific clinically significant reason why current factor product cannot be used (or Feiba® and NovoSeven® if requesting Obizur®) must be provided:

6. Has a half-life study been performed? Yes ___ No ___ Date(s) performed: _____
7. For extended half-life factor products was there a significant benefit seen in half-life? Yes ___ No: ___

I recommend this patient be followed by an OHCA Care Management Nurse.

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:
 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

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