

**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: _____
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  - 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<sup>®</sup> 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:

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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