Etranacogene dezaparvovec-drlb (Hemgenix)

peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____ /____ /_____
Daytime Phone:	Evening Phone:		*Sex: ☐ Male ☐ Female

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #:	Group #:	ID #:	Group #:

Physician Information

*Name:	*Specialty:	NPI:
*Phone #:	Secure Fax #:	Office Contact:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Congenital hemophilia B (factor IX deficiency) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Hemgenix (etranacogene dezaparvovec-drlb)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY

Therapy start date: _____

1. Is Hemgenix prescribed by or in consultation with a hematologist? ☐Yes ☐No
2. Has patient had severe or moderately severe hemophilia? ☐Yes ☐No
3. Please provide the following patient information:
   a) Weight: _____ kg
   b) Factor IX level: _____ %
   c) Inhibitor level assay (within last 12 months): _____ Bethesda units (BU), date: _____
   d) Adeno-associated virus serotype 5 (AAV5) neutralizing antibody titer: _____ : _____
4. Has patient been adherent with use of a factor IX product for routine prophylaxis for at least 12 months as assessed and documented by prescriber? ☐Yes ***Mark all that apply*** ☐No
   ☐Alprolix ☐Benefix ☐Idelvion ☐Ixinity ☐Rebinyn ☐Rixubis ☐Other: _____
5. Has patient been treated with factor IX product for a minimum of 150 exposure days (ED)*?
   ☐Yes ***Mark all that apply*** ☐No
   **ED defined days on which factor was infused with factor concentrate to treat or prevent a bleed on a person with hemophilia.*
6. Has patient had occurrence of at least 1 serious spontaneous bleeding event while on routine prophylaxis?
   ☐Yes ***Mark all that apply*** ☐No
   ☐Intracranial ☐Neck/throat ☐Gastrointestinal ☐Joints (hemarthrosis) ☐Muscles (e.g., iliopsoas, calf, forearm)
   ☐Mucous membranes of the mouth, nose & genitourinary tract ☐Other: _____
7. Is there documented history of a detectable factor IX inhibitor? ☐Yes ☐No
8. Has patient had initial factor IX inhibitor positive test? ☐Yes ☐No
   a) *If* yes, is there documentation of subsequent negative test within 2 weeks?
   ☐Yes, positive test date: _____ and negative test date: _____ ☐No
9. Has patient had both of the following documented baseline liver assessments within the last 3 months?
   ☐Yes ***Mark all that apply*** ☐No
   ☐Normal hepatic ultrasound and elastography
   ☐Liver enzymes within normal limits (e.g., alanine aminotransferase, aspartate aminotransferase, alkaline phosphatase & total bilirubin)

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Please continue to page 2.

Patient Name: _____ **DOB:** _____

10. Has patient had evidence of radiological liver abnormalities and/or sustained liver enzyme elevations? ☐Yes ☐No
    a) *If yes*, does hepatologist attest that patient is eligible for Hemgenix? ☐Yes ☐No
11. Has patient received prior gene therapy? ☐Yes ☐No

Complete this section ONLY for indications other than congenital hemophilia B:

12. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies: _____
    b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Physician's Signature: _____ **Date:** _____ ☐DAW

INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	**Coverage:** ☐State excludes ☐COB (secondary)
***Line of Business:** ☐Commercial ☐Health Insurance Marketplace ☐Medicaid ☐Medicare	***Benefit:** ☐Medical ☐Pharmacy

***Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐Medicare Local Coverage Decision (LCD) specific for your region.
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00

☐Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00

Medicaid, Commercial, Exchange (Ambetter):

☐Centene Policy [**CP.PHAR.580 Etranacogene Dezaparvovec-drlb (Hemgenix)]**
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

OR

☐State or Health Plan Specific (please include policy) _____