peach state health plan

Fidanacogene Elaparvovec (Beqvez)

Prior Authorization Form/Prescription

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

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
Beqvez (Fidanacogene Elaparvovec)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

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

Therapy start date: _____

1. Is therapy prescribed by or in consultation with a hematologist? ☐Yes ☐No
2. Please provide patient's weight: _____ kg
3. Does patient have severe or moderately severe hemophilia? ☐Yes, factor IX level _____ % ☐No
4. Is there documentation that patient has been adherent with use of a factor IX product for routine prophylaxis for at least 6 months? ☐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 50 exposure days? ☐Yes **Mark all that apply** ☐No
   ☐Alprolix ☐Benefix ☐Idelvion ☐Ixinity ☐Rebinyn ☐Rixubis ☐Other: _____
6. Has there been at least 1 occurrence of serious spontaneous bleeding event while on routine prophylaxis?
   ☐Yes **Mark all that apply** ☐No
   ☐Intracranial ☐Neck/throat ☐Gastrointestinal ☐Joints (hemarthrosis
   ☐Muscles (deep compartments such as the iliopsoas, calf, forearm)
   ☐Mucous membranes of the mouth, nose and genitourinary tract ☐Other: _____
7. Is there documented history of a detectable factor IX inhibitor? ☐Yes ☐No
8. Is there documentation of inhibitor level assay < 0.6 Bethesda units (BU) within the last 12 months?
   ☐Yes, _____ BU, date: _____ ☐No
9. Did patient have an initial positive test result for factor IX inhibitor? ☐Yes, date: _____ ☐No
   a. *If yes*, Is there documentation of a subsequent negative test within 2 weeks? ☐Yes, date: _____ ☐No
10. Has patient had all of the following baseline liver assessments within the last 3 months?
    ☐Yes **Mark all that apply** ☐No
    ☐Documentation of liver enzymes within normal limits (e.g., ALT, AST, ALP)
    ☐Documentation of normal hepatic ultrasound and elastography
    ☐Evidence of radiological liver abnormalities and/or sustained liver enzymes elevations
11. Does hematologist attest patient is eligible for Beqvez? ☐Yes ☐No
12. Has patient received prior gene therapy? ☐Yes ☐No
13. Is there documentation of anti-AAV-Spark100 neutralizing antibody titer < 1:1? ☐Yes ☐No

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications other than Congenital Hemophilia B (factor IX deficiency):

14. 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 COMPLETE 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) Criteria:

☐ Centene Policy [**CP.PHAR.643 Fidanacogene Elaparvovec (Beqvez)**]
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) _____