Clotting Factors

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:

☐ Advate (J7192)
☐ Adynovate (J7207)
☐ Afstyla (J7210)
☐ Alphanate (J7186)
☐ AlphaNine SD (J7193)
☐ Alprolix (J7201)
☐ Altuviiio
☐ ATryn (J7196)
☐ BeneFIX (J7195)
☐ Coagadex (J7175)
☐ Corifact (J7180)
☐ Eloctate (J7205)
☐ Esperoct (J7199)
☐ Feiba (J7198)
☐ Fibryga (J3490)
☐ Hemlibra
☐ Hemofil M (J7190)
☐ Humate-P (J7187)
☐ Idelvion (J7202)
☐ Ixinity (J7195)
☐ Jivi (J7199)
☐ Koate (J7190)
☐ Kogenate FS (J7192)
☐ Kovaltry (J7192)
☐ NovoSeven RT (J7189)
☐ Novoeight (J7182)
☐ Nuwiq (J7192)
☐ Obizur (J7188)
☐ Profilnine (J7194)
☐ Rebinyn (J7195)
☐ Recombinate (J7192)
☐ RiaSTAP (J7178
☐ Rixubis (J7200)
☐ Sevenfact (J7212)
☐ Thrombate III (J7197)
☐ Tretten (J7181)
☐ Vonvendi (J7179)
☐ Wilate (J7183)
☐ Xyntha (J7185)

Dosage Information:
Units per dose: Directions: Number of doses required per month:

Patient's current weight: ICD10:

(for all but AlphaNine SD, Alprolix, Altuviiio, BeneFIX, Idelvion, Ixinity, Profilnine, Rebinyn, or Rixubis) Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".
☐ New start
☐ Continuation of therapy

(if continuation of therapy) Is there documentation your patient has had a beneficial response with the requested medication?
☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis (check all that apply to your patient):

☐ acquired hemophilia A
☐ acquired inhibitor titer to Factor VIII
☐ acquired inhibitors to factors XI or XII
☐ coagulation factor X deficiency
☐ congenital fibrinogen deficiency (factor I deficiency)-afibrinogenemia
☐ congenital fibrinogen deficiency (factor I deficiency)-hypofibrinogenemia
☐ congenital fibrinogen deficiency (factor I deficiency)-dysfibrinogenemia
☐ congenital factor VII (FVII) deficiency
☐ congenital factor XIII A-subunit deficiency
☐ congenital factor XIII B-subunit deficiency
☐ congenital Factor XIII deficiency
☐ factor II deficiency
☐ factor VIII deficiency (hemophilia A)
☐ factor IX deficiency (hemophilia B)
☐ factor X deficiency
☐ factor XIII deficiency
☐ Glanzmann's thrombasthenia with refractoriness to platelet transfusions
☐ hemophilia A
☐ hemophilia A (congenital factor VIII deficiency)
☐ hemophilia A with inhibitors
☐ hemophilia B
☐ hemophilia B with inhibitors
☐ hereditary antithrombin deficiency (antithrombin III deficiency, AT III deficiency)
☐ hereditary Factor X deficiency
☐ inhibitors to factors XI or XII
☐ severe von Willebrand disease (VWD)
☐ mild or moderate von Willebrand disease (VWD)
☐ Other (please specify):

Clinical Information

****FEIBA, NovoSeven RT, Obizur, SEVENFACT and Tretten: These drugs requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

(if AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Profilnine, Rebinyn, or Rixubis) Is this agent prescribed by (or in consultation with) a hemophilia specialist? ☐ Yes ☐ No

(if AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Profilnine, Rebinyn, or Rixubis AND has hemophilia B) Is this medication being used as on-demand treatment and control of bleeding episodes? ☐ Yes ☐ No

(if no) Is this medication being used for routine prophylaxis? ☐ Yes ☐ No

(if no) Is this medication being used for perioperative management? ☐ Yes ☐ No

(if no and requesting **AlphaNine SD, BeneFIX, Ixinity, Profilnine or Rixubis**) Is this medication being used for immune tolerance therapy (also known as immune tolerance induction)? ☐ Yes ☐ No

if Advate, Adynovate, Afstyla, Coagadex, Eloctate, Esperoct, Hemofil M, Jivi, Koate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha) For which of the following is the requested drug being used?

☐ On-demand treatment and control of bleeding episodes
☐ Peri-operative management of bleeding
☐ Routine prophylaxis to reduce the frequency of bleeding episodes
☐ Other
  ☐ (if peri-operative) What is/was the date of surgery?
  ☐ (if prophylaxis) What is the frequency of bleeding episodes?
  ☐ (if other) Why is this drug being prescribed?

(if Alphanate with vWD) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following: A. Concentrated intranasal desmopressin (Stimate) B. Parenteral desmopressin (DDAVP injection)? ☐ Yes ☐ No

(if Alphanate) For which of the following is Alphanate being used?

☐ treatment of current active bleed
☐ prevention of excessive bleeding during and/or following surgery
☐ routine prophylaxis
☐ as needed dosing for future bleeds
☐ other

(if as needed dosing) What is the approximate number of bleeds requiring factor treatment per month?

(if surgery) What is the date of the surgery/procedure?

(if surgery and type III vWD) Is your patient undergoing major surgery? ☐ Yes ☐ No

(if other) Please provide clinical rationale for the use of Alphanate in your patient.

(if ATryn) Is ATryn being used for the prevention of perioperative or peripartum events? ☐ Yes ☐ No

(if Fibryga or RiaSTAP) Has the patient had testing showing prolonged activated partial thromboplastin time and prothrombin time at baseline, as defined by the laboratory reference values? ☐ Yes ☐ No

(if Fibryga or RiaSTAP) Has the patient had testing showing lower than normal plasma functional and antigenic fibrinogen levels at baseline, as defined by the laboratory reference values? ☐ Yes ☐ No

(**if Fibryga or RiaSTAP**) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(**if Fibryga or RiaSTAP**) Will both Fibryga and RiaSTAP be taken together at the same time? ☐ Yes ☐ No

(If yes) Please provide the clinical rationale for concurrent use:

(if Coagadex)
For which of the following is this drug being used?
☐ Peri-operative management of bleeding in individuals with mild, moderate, or severe hereditary Factor X deficiency
☐ Routine prophylaxis to reduce the frequency of bleeding episodes
☐ Treatment of bleeding episodes
☐ Other

(if other) Please provide clinical rationale for the use of this drug in your patient.

(if Altuviiio, Corifact, Tretten)
For which of the following is this drug being used?
☐ Peri-operative management of bleeding
☐ Routine prophylaxis to reduce the frequency of bleeding episodes
☐ Treatment of bleeding episodes
☐ Other

(if other) Please provide clinical rationale for the use of this drug in your patient.

(if Altuviiio)
Is this a request for initial therapy or is the patient currently receiving the requested medication (or they have in the past)? If patient has been taking samples, please pick 'initial therapy'.
☐ Initial therapy
☐ Currently receiving the requested medication (or they have in the past)

(if currently receiving therapy or have in the past) Does the patient have clinical manifestations suggesting the presence of Factor VIII inhibitors? Please Note: Inhibitors may be present if bleeding is not well controlled, there is decreased responsiveness to Factor VIII therapy, and/or if expected Factor VIII activity plasma levels are not achieved. ☐ Yes ☐ No

(if currently receiving therapy or have in the past) Has Factor VIII inhibitor testing been performed within the last 365 days? ☐ Yes ☐ No

(if currently receiving therapy or have in the past) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 0.6 Bethesda units/mL? ☐ Yes ☐ No

(if initial therapy) Has the patient received Factor VIII therapy in the past? ☐ Yes ☐ No

(if initial therapy) Has Factor VIII inhibitor testing been performed within the last 30 days? ☐ Yes ☐ No

(if initial therapy) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 1.0 Bethesda units/mL? ☐ Yes ☐ No

Is the requested medication being prescribed by (or in consultation with) a hematologist or hemophilia specialist? ☐ Yes ☐ No

Is this a request for initial therapy or is the patient currently receiving the requested medication (or they have in the past)? If patient has been taking samples, please pick 'initial therapy'.
☐ Initial therapy
☐ Currently receiving the requested medication (or they have in the past)

(if currently receiving therapy or have in the past) Does the patient have clinical manifestations suggesting the presence of Factor VIII inhibitors? Please Note: Inhibitors may be present if bleeding is not well controlled, there is decreased responsiveness to Factor VIII therapy, and/or if expected Factor VIII activity plasma levels are not achieved. ☐ Yes ☐ No

(if currently receiving therapy or have in the past) Has Factor VIII inhibitor testing been performed within the last 365 days? ☐ Yes ☐ No

(if currently receiving therapy or have in the past) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 0.6 Bethesda units/mL? ☐ Yes ☐ No

(if initial therapy) Has the patient received Factor VIII therapy in the past? ☐ Yes ☐ No

(if initial therapy) Has Factor VIII inhibitor testing been performed within the last 30 days? ☐ Yes ☐ No

(if initial therapy) Does the patient have a positive test for Factor VIII inhibitors greater than or equal to 1.0 Bethesda units/mL? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with, a hemophilia specialist? ☐ Yes ☐ No

(if Vonvendi)
For which of the following is this drug being used?
☐ Peri-operative management of bleeding
☐ Routine prophylaxis to reduce the frequency of bleeding episodes in individuals with severe Type 3 von Willebrand disease
☐ Treatment of bleeding episodes
☐ Other

(if other) Please provide clinical rationale for the use of this drug in your patient.

(if Coagadex, Corifact, Tretten, Vonvendi) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Hemlibra) Is there documentation that your patient has one of the following?
☐ factor XIII inhibitors
☐ mild or moderate hemophilia (defined as factor VIII level of 1% to less than 40%)
☐ severe hemophilia defined as pre-treatment factor VIII level less than 1%
☐ none of the above

(if mild/moderate) Which of the following applies to your patient? Please provide documentation
☐ 1 or more episodes of bleeding into the central nervous system or other serious, life-threatening bleed
☐ 1 or more episodes of bleeding into large joint (ankles, knees, hips, elbows, shoulders) and age 3 years or younger
☐ 2 or more episodes of bleeding into large joints (ankles, knees, hips, elbows, shoulders)
☐ presence of joint disease documented by physical examination and plain radiographs of the affected joints
☐ none of the above

(if Hemlibra) Is Hemlibra being used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ☐ Yes ☐ No

(if no) Please specify the use for which Hemlibra is being prescribed.

(if Humate-P and type I or II vWD) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following: A. Concentrated intranasal desmopressin (Stimate) B. Parenteral desmopressin (DDAVP injection)? ☐ Yes ☐ No

(if Humate-P, Obizur) For which of the following is the drug requested being used?
☐ treatment of current active bleed
☐ prevention of excessive bleeding during and/or following surgery
☐ routine prophylaxis
☐ as needed dosing for future bleeds
☐ other

(if surgery) What is the date of surgery?
(if as needed dosing) What is the approximate number of bleeds requiring factor treatment per month?
(if other) Please provide clinical rationale for the use of this drug in your patient.

(if Jivi) Has your patient been previously treated for this diagnosis? Examples include Advate, Adynovate, Afstyla, Alphanate, Eloctate, Feiba, Helixate FS, Hemlibra, Hemofil M, Humate-P, Koate, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate, Xyntha. ☐ Yes ☐ No

(if Obizur) (if acquired hemophilia) Has there been documentation provided of autoimmune inhibitory antibodies to human factor VIII? ☐ Yes ☐ No

(**if Obizur**) Does the patient have a diagnosis of either congenital hemophilia A or von Willebrand's disease? ☐ Yes ☐ No

(**if NovoSeven RT**) (if Glanzmann's thrombasthenia) Is the patient refractory to platelet transfusions? ☐ Yes ☐ No

Feiba, NovoSeven RT or Sevenfact:

Is the drug requested being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Hemophilia A with inhibitors) Does the patient have a positive inhibitor titer at least 5 Bethesda Units or greater? ☐ Yes ☐ No

(if no to previous question) Does the patient have a history of an inhibitor with anamnestic response to Factor VIII replacement therapy, which precludes the use of Factor VIII replacement to treat bleeding episodes? ☐ Yes ☐ No

(if no to previous question) Does the patient have a history of an inhibitor with refractory hemostatic response to increased Factor VIII dosing, which precludes the use of Factor VIII replacement to treat bleeding episodes? ☐ Yes ☐ No

(if Hemophilia B with inhibitors) Does the patient have a positive inhibitor titer at least 5 Bethesda Units or greater? ☐ Yes ☐ No

(if no to previous question) Does the patient have a history of an inhibitor with anamnestic response to Factor IX replacement therapy, which precludes the use of Factor IX replacement to treat bleeding episodes? ☐ Yes ☐ No

(if no to previous question) Does the patient have a history of an inhibitor with refractory hemostatic response to increased Factor IX dosing, which precludes the use of Factor IX replacement to treat bleeding episodes? ☐ Yes ☐ No

(if Thrombate III) Is Thrombate III being used to treat or prevent pulmonary or deep vein embolisms (PE, DVT)? ☐ Yes ☐ No

If yes, please include the most recent clinical notes.

(if Thrombate III) Is your patient undergoing a surgical or obstetrical procedure? ☐ Yes ☐ No

(if Tretten) Is this drug being used for routine prophylaxis of bleeding? ☐ Yes ☐ No

(if no) What is the diagnosis related to use?

(if Tretten) Does your patient have documented A-subunit deficiency? ☐ Yes ☐ No

If yes, please include documentation.

(if Wilate) For which of the following is Wilate being used?
☐ treatment of current active bleed or as needed dosing for future bleeds
☐ routine prophylaxis
☐ management of bleeding associated with surgery (including prevention of excessive bleeding)
☐ other

(if surgery) What is the date of surgery?
(if other) Please provide clinical rationale for the use of Wilate in your patient.

(if Wilate and mild to moderate vWD) Does your patient have documented failure/inadequate response, contraindication per FDA label, intolerance, not a candidate for, OR is your patient not able to obtain BOTH of the following: A. Concentrated intranasal desmopressin (Stimate) B. Parenteral desmopressin (DDAVP injection)? ☐ Yes ☐ No

Additional pertinent information: Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc).

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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