UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hemgenix (etranacogene dezaparvovec-drlb)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: ***(ALL** the following criteria must be met)*

- ❑ Prescribed by a hematologist, specializing in the care of patients with hemophilia B
- ❑ The patient is 18 years of age or older
- ❑ Patient has a negative Factor IX inhibitor titer
- ❑ Patient has confirmed diagnosis of hemophilia B (congenital Factor IX deficiency) **AND**:
  - Currently uses Factor IX prophylaxis therapy, **OR**
  - Has current or historical life-threatening hemorrhage, **OR**
  - Has repeated, serious spontaneous bleeding episodes
- ❑ The provider selects **ONE** of the following:
  - ❑ Patient has a negative adeno-associated virus serotype 5 (AAV5) neutralizing antibody assay **OR**
  - ❑ The patient has pre-existing anti-AAV5 titer of ≤678 only
- ❑ Provider **attests** that patient has completed liver health assessments, including the following:
  - Enzyme testing [alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase (ALP) and total bilirubin)]
  - Hepatic ultrasound and elastography
  - Active infection with hepatitis B or C
  - The patient has never received Hemgenix before
- ❑ Provider **attests** to complete all post-infusion monitoring described in the current Hemgenix prescribing information.

Initial Authorization Period: One intravenous infusion

Re-authorization Period: Not applicable

Note:

- Use appropriate HCPCS code for billing.
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary, and meets the guidelines for use.

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Prescriber's Signature Date