UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

ROCTAVIAN (valoctocogene roxaparvovec-rvox)

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 A
- ❑ Patient is 18 years of age or older
- ❑ Patient has not received Roctavian or any other gene therapy before
- ❑ Patient has the diagnosis of severe hemophilia A (congenital Factor VIII (FVIII) deficiency with FVIII activity < 1 IU/dL)
- ❑ Patient does not have antibodies to adeno-associated virus serotype 5 (AAV5) as detected by an FDA-approved test.
- ❑ Patient has no previous documented history of detectable factor VIII inhibitor
- ❑ Prescriber **attests** to these following assessments prior to administer Roctavian:
    - Obtaining and evaluating liver function tests
    - Assessing the patient's ability to receive corticosteroids and / or other immunosuppressive therapy that maybe required for an extended period
    - That the patient **does not** have active infections, either acute or uncontrolled chronic infections.
    - That patient **does not** have any known significant hepatic fibrosis (stage 3 or 4 on the Batts-Ludwig scale or equivalent) or cirrhosis, or mannitol hypersensitivity.

Initial Authorization: One (1) dose per lifetime
Re-authorization Criteria: None

Note:

- Use appropriate HCPCS codes 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.

_____ _____

Prescriber's Signature Date