



ANTIHEMOPHILIA AGENTS PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Antihemophilia Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION.

Drug #1 requested:	Strength & package size:	
Directions:	Quantity:	Refills:
Drug #2 requested:	Strength & package size:	
Directions:	Quantity:	Duration:
Diagnosis (submit documentation):	Dx code (required):	
Is the medication prescribed by a hematologist or hemophilia treatment center practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the beneficiary currently being treated with the requested medication? <input type="checkbox"/> Yes – date of last dose: _____ <input type="checkbox"/> No		

Complete the section(s) below applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

INITIAL requests

1. Request is for a NON-FACTOR REPLACEMENT Antihemophilia Agent (e.g., Alhemo, Hemlibra, Hympavzi, Qfitlia):

Has one of the following diagnoses:

Hemophilia A	Hemophilia B
<input type="checkbox"/> severe congenital hemophilia A	<input type="checkbox"/> severe congenital hemophilia B
<input type="checkbox"/> congenital hemophilia A with inhibitors	<input type="checkbox"/> congenital hemophilia B with inhibitors
<input type="checkbox"/> congenital hemophilia A and a history of at least 1 spontaneous joint bleed or other serious bleeding event	<input type="checkbox"/> congenital hemophilia B and a history of at least 1 spontaneous joint bleed or other serious bleeding event
<input type="checkbox"/> acquired hemophilia A (emicizumab only)	



For a **non-preferred non-factor replacement Antihemophilia Agent:**

- Tried and failed or cannot try (due to a contraindication or an intolerance) the preferred non-factor replacement agents approved or medically accepted for the beneficiary's diagnosis (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)

2. Request is for a BYPASSING AGENT (eg, FEIBA NF, NovoSeven, Sevenfact):

- Has hemophilia A with inhibitors AND:
 - Is using the requested medication for episodic/on-demand treatment OR intermittent/periodic prophylaxis
 - Is using the requested medication for routine prophylaxis AND:
 - Failed to achieve clinical goals with Hemlibra (emicizumab)
 - Has a medical reason why Hemlibra (emicizumab) cannot be used
 - Has been using the requested bypassing agent for routine prophylaxis within the past 90 days
- Has hemophilia B with inhibitors
- Has acquired hemophilia
- Has congenital factor VII deficiency
- Has Glanzmann's thrombasthenia

3. Request is for a non-preferred FACTOR VIII, FACTOR IX, or VWF:

- Both of the following:
 - Has been using the requested medication within the past 90 days
 - Has a medical reason to continue using the requested medication
- Failed to achieve clinical goals with or has a contraindication or an intolerance to the preferred FVIII, FIX, or FVIII/VWF medications with the same half-life (standard v. extended half-life), if applicable. *Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*
- Has a diagnosis for which no preferred Antihemophilia Agents are appropriate. *Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*

RENEWAL requests

- Experienced a positive clinical response since starting the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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