Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Antihemophilia Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Provide the diagnosis below:

Diagnosis:_____ICD-10 Code(s): _____

Is the diagnosis an FDA approved indication, or is the diagnosis supported for use by one of the following? ❑ **Yes** ❑ **No**

- American Hospital Formulary Service Drug Information (AHFS DI); or
- FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table); or
- Both of the following:
  - Diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table); and
  - Efficacy is rated as “effective” or “evidence favors efficacy” (see DRUGDEX Efficacy Rating and Prior Authorization Approval Status table); or
- Diagnosis is supported in any other section of DRUGDEX

If **no,** will the prescriber additionally submit two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal? ❑ **Yes** ❑ **No** ❑ **N/A**

Prescriber’s Specialty:

Is the prescriber a specialist in treating hemophilia? ❑ **Yes** ❑ **No**

Clinical Information:

Will the dispensing provider monitor the amount of product a recipient has left to avoid over-stock? ❑ **Yes** ❑ **No**

Is this request for a dose adjustment in excess of 5% (increase or decrease)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.