Alaska Medicaid





Prescribing/Treatment Plan Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units. Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

	Request Date:
REQUESTOR INFORMATION	
Requestor Name:	Title:
MEMBER INFORMATION	
Last Name:	First Name:
Member ID #:	Date of Birth:
Sex: Male Female	Member Phone:
What is the members weight (in kg)?	
PRESCRIBER INFORMATION	
Last Name:	First Name:
Prescriber NPI:	Specialty:
Prescriber Phone:	Prescriber Fax:
PHARMACY INFORMATION	
Pharmacy Name:	Pharmacy NPI:
Pharmacy Phone:	Pharmacy Fax:
DRUG INFORMATION	
Drug Name:	NDC:
Drug Strength:	Dosage Form:
Prophylaxis:	
Dose/Units/Kg:	Quantity: Refills:

Revision Date: 05/14/2024

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Alaska Medicaid Hemlibra® Prior Authorization Form First Name:

Las	st Name: First Name:
Is t	his a physician-administered drug?
PR	ESCRIPTION INFORMATION
1.	Is the prescriber affiliated with the regional hemophilia treatment center? \square Yes \square No
2.	Does the prescriber attest that the patient will comply with the requirement to log infusions? \square Yes \square No
3.	Does the member have a diagnosis of hemophilia A and have documented congenital factor VIII deficiency confirmed by blood coagulation testing? Yes No
4.	Is Hemlibra being used in combination with immune tolerance induction (ITI)? \square Yes \square No
5.	Will this medication be used as routine prophylaxis to prevent or reduce bleeds? \square Yes \square No
6.	For renewals only: Is there documentation of positive response, as evidenced by a reduction in spontaneous bleeds, which has been verified by the prescriber? ☐ Yes ☐ No
	Attachments
	estation: I hereby certify that this treatment is indicated and necessary and meets guidelines for use as outlined by Alaska Medicaid.
Pre	escriber Signature: Date:
(red	quired)
	me Therapeutics Management LLC
	n: GV - 4201
	Dayl MN 55164 0811
	Paul, MN 55164-0811 one: (800) 331-4475
1 110	AICT (OOO) SSI TT/S

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