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WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

HEMGENIX PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

| | | |
|--|----------------|-----------------------|
| Date: | | |
| RECEIPIENT INFORMATION | | |
| Medicaid ID: | Date of Birth: | Sex: M F |
| Last Name: | | First Name: |
| GENERAL INFORMATION | | |
| First Date of Service: | | Last Date of Service: |
| Primary Diagnosis Code: | | HCPC Code: |
| Drug Name: | | Dose & Frequency: |
| Hospitalizations/Treatments/Medications Used in the last 6 months: | | |
| POINT OF CONTACT | | |
| Name and Title: | | |
| Email: | Phone: | Fax: |
| <small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small> | | |
| REFERRING PROVIDER INFORMATION | | |
| Name: | | |
| NPI #: | | Taxonomy: |
| Phone: | | Fax: |
| SERVICING PROVIDER INFORMATION | | |
| Name: | | |
| Address: | | |
| NPI #: | | Taxonomy: |
| Phone: | | Fax: |

| CRITERIA | | |
|--|---|-------------------|
| Medical records to support use of product are submitted | | |
| Initial Therapy (check one) | Yes | No |
| | Therapy is prescribed by a hematologist | |
| | Individual has a diagnosis of hemophilia B (congenital Factor IX deficiency) confirmed via factor IX assay | |
| | Disease severity is classified as moderate to severe with Factor IX levels $\leq 2\%$ of normal | |
| | Individual was assigned male sex at birth and is ≥ 18 years of age | |
| | Individual meets one of the following regarding necessity therapy: <ul style="list-style-type: none"> • Current use of Factor IX prophylaxis therapy (e.g., AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine, Profilnine SD, Rebinyn, Rixubis) • Current or historical life-threatening hemorrhage • History of repeated, serious spontaneous bleeding episodes | |
| | Documentation is submitted indicating the individual has a minimum of 150 exposure days to Factor IX therapy | |
| | Documentation is provided showing individual is negative for Factor IX inhibitor titers within the last 30 days – If initial test was positive, subsequent negative test must be done within 2 weeks. If both initial and subsequent test are positive, Hemgenix should not be given and will not be approved. Documentation of all drawn titers must be submitted with Hemgenix request. | |
| | Documentation is submitted indicating individual has been tested for presence of anti-adenovirus serotype 5 (AAV5) antibodies and level is < 700 | |
| | Documentation is provided indicating that baseline liver function tests (AST, ALT and total bilirubin) were performed and determined to be within normal limits (if there is evidence of liver abnormalities, sign off from a hepatologist indicating eligibility for Hemgenix is required before SD Medicaid will approve prior authorization request) | |
| | Prescriber attests individual does not have any of the following active diseases: hepatitis B or C, HIV, decompensated cirrhosis | |
| | Individual has not received prior gene therapy | |
| PHYSICIAN SIGNATURE – PROVIDER ONLY | | |
| This form <u>must be</u> signed by a hematologist | | |
| | I certify that the information given in this form is a true and accurate medical indication for the required product | |
| Name & Title (Printed): | | Specialty: |
| Signature: | | |