

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

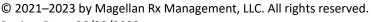
Hemgenix™ (etranacogene dezaparvovec-drlb)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION F	EQUESTED													
LAST NAME:	FIRST NAME:													
MEDICAID ID NUMBER:	DATE OF BIRTH:													
GENDER: Male Female														
Drug Name:	Strength:													
Dosing Directions:	Length of Therapy:													
SECTION II: PRESCRIBER INFORMATION														
LAST NAME:	FIRST NAME:													
SPECIALTY:	NPI NUMBER:													
PHONE NUMBER:	FAX NUMBER:													
SECTION III: CLINICAL HISTORY														
Is the prescriber a hematologist?	Yes No													
2. Is the patient managed by a hemophilia treatment ce	nter? Yes No													
3. Does the patient have moderately severe to severe co	ongenital factor IX deficiency, confirmed by Yes 🔲 No													
blood coagulation testing?														
4. Provide clinical information confirming patient has ha	d one or more of the following:													
a. Use of factor IX prophylaxis (provide therapy and	dates):													
b. Life-threatening hemorrhage (provide detail and o	dates):													
c. Repeated, serious spontaneous bleeding episodes	(provide detail and dates):													
(Form continued on next page.)														

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101



Review Date: 06/29/2023





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PATIENT LAST NAME:	PATIENT FIRST NAME:													
SECTION III: CLINICAL HISTORY														
5. Is the patient negative for factor IX inhibitor titers or	n initial test or re-test?													
6. Will the Factor IX activity be monitored periodically?	Yes N													
7. Will the patient be monitored for factor IX inhibitors	if bleeding is not controlled?													
8. Will the liver function be assessed after Hemgenix® of	dose weekly for at least 3 months?													
a. Attach copy of baseline liver function tests.														
9. Does the patient have any of the following:	☐ Yes ☐ N													
 Cirrhosis Advanced hepatic fibrosis Hepatitis B Hepatitis C Non-alcoholic fatty liver disease Chronic alcohol consumption Non-alcoholic steatohepatitis Advanced age 														
10. Attach protocol for post-Hemgenix® monitoring.														

(Form continued on next page.)

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SECTION	I III: CI	LINIC	AL H	ISTOF	RY (Ca	ntinu	ied)	•	•	-					•	•	•	1	•	•	•	1	
Please p	rovide	any	addi	tional	linfor	matic	on tha	at wo	uld h	elp	in th	e de	cisio	n-ma	ıking	proc	ess. I	fadd	itiona	al spa	ce is		
needed,	pleas	e use	a se	parat	e she	et.																	
I certify t					-						-				-		_				and t	hat	
PRESCRI	BER'S	SIGN	IATU	JRE: _													D	ATE:					
Facility v	where	infus	ion t	o be ı	provid	ded:	_																
Medicai	d Prov	ider I	Num	ber o	f Facil	ity:																	

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