



**Anti-Hemophilic  
 FACTOR IX (Non-Recombinant J7193, Complex  
 J7194, Recombinant NOS) J7195, Alprolix J7201,  
 Idelvion J7202, Rebinyn J7203, Rixubis J7200  
 Prior Authorization Request  
 Medicare Part B Form**

*Instructions: \* Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	<b>Standard Request– (72 Hours)</b>	<input type="checkbox"/>	<b>Urgent Request</b> (standard time frame could place the member's life, health or ability in serious jeopardy)
Date Requested _____			
Requestor _____ Clinic name: _____ Phone _____ / Fax _____			

**MEMBER INFORMATION**

\*Name: \_\_\_\_\_ \*ID#: \_\_\_\_\_ \*DOB: \_\_\_\_\_

**PRESCRIBER INFORMATION**

\*Name: \_\_\_\_\_  MD  FNP  DO  NP  PA \*Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ \*Fax: \_\_\_\_\_

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

\*Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**PROCEDURE / PRODUCT INFORMATION**

HCP Code	Name of Drug	Dose (Wt: _____ kg Ht: _____ )	Frequency	End Date if known

Self-administered       Provider-administered       Home Infusion

Chart notes attached. **Other important information:** \_\_\_\_\_

**Diagnosis: ICD10:** \_\_\_\_\_ **Description:** \_\_\_\_\_

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

New Start or Initial Request: (Clinical documentation required for all requests)  
 **Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.**  
 If not, please provide **clinical rationale** for formulary exception: \_\_\_\_\_

Continuation Requests: (Clinical documentation required for all requests)  
 **Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.**  
 Patient had an adequate response or significant improvement while on this medication.  
 If not, please provide clinical rationale for continuing this medication: \_\_\_\_\_

**ACKNOWLEDGEMENT**

**Request By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

## Prior Authorization Group – Coagulation Factors PA

### Drug Name(s):

FACTOR IX (Non-Recombinant)  
FACTOR IX (Complex)  
FACTOR IX (Recombinant NOS)  
ALPROLIX  
IDELVION  
REBINYN  
RIXUBIS

### Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
  - a. On-demand treatment and control of bleeding episode
  - b. Routine prophylaxis to reduce the frequency of bleeding episodes
  - c. Perioperative management of bleeding
2. Patient does NOT have one of the following conditions:
  - a. Disseminated intravascular coagulation OR
  - b. Signs of fibrinolysis (Rixubis only)
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
  - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
  - Quantity limits and Tiering will be determined by the Plan.

### Exclusion Criteria:

Disseminated intravascular coagulation (DIC) (Rixubis only)  
Signs of fibrinolysis (Rixubis only)

### Prescriber Restrictions:

N/A

### Coverage Duration:

Approval will be for 12 months

### FDA Indications:

#### All Factor IX Products:

- Diagnosis of Hemophilia B
  - On-demand treatment and control of bleeding episodes
  - Routine prophylaxis to reduce the frequency of bleeding episodes
  - Perioperative management of bleeding

### Off-Label Uses:

- Blood coagulation disorder – disease of liver
- Factor X deficiency; Prophylaxis
- Toxicity of drug, Anticoagulant

### Age Restrictions:

N/A

**Other Clinical Consideration:**

**N/A**

**Resources:**

[https://www.micromedexsolutions.com/micromedex2/librarian/CS/D548C8/ND\\_PR/evidencexpert/ND\\_P/evidencexpert/DUPLICATIONSHIELDSYN C/54F6A6/ND\\_PG/evidencexpert/ND\\_B/evidencexpert/ND\\_AppProduct/evidencexpert/ND\\_T/evidencexpert/PFActionId/evidencexpert.DoIntegrat edSearch?SearchTerm=factor%20ix&UserSearchTerm=factor%20ix&SearchFilter=filterNone&navitem=searchGlobal](https://www.micromedexsolutions.com/micromedex2/librarian/CS/D548C8/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYN C/54F6A6/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegrat edSearch?SearchTerm=factor%20ix&UserSearchTerm=factor%20ix&SearchFilter=filterNone&navitem=searchGlobal)

Clinical / CMS  
Only