BOSTON MEDICAL CENTER HealthNet Plan

ENVISION Rx OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
BMCHPQHP Blood Clotting Disorder Medications (2)
Policy 9.165
FEIBA VH, FEIBA NF, NovoSeven, NovoSeven RT
Phone: 855-264-4964 Fax back to: 877-503-7231

manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy? If continuing therapy, include the treatment start date.

☐ Initial
☐ Continuing / Start date (mm/yy):

Q2. Please indicate the patient 's diagnosis below:

☐ Acquired hemophilia
☐ Congenital factor VII deficiency with an acute bleeding episode or increased risk of bleeding due to a clinical situation (i.e. trauma or surgery)
☐ Persistent inhibitors to factor concentrates has developed
☐ Other (please specify):

Q3. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q4. If coverage of medication is approved, how will this medication be supplied? (Please check one)

☐ Order through Orchard Specialty Pharmacy
☐ Provider/Hospital Buy & Bill

Q5. If Buy and Bill, please provide the following information:

☐ J-codes:____

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Patient Name:	**Prescriber Name:**

☐ Procedure code(s) for administration of medication:______________________________________

☐ Number of Units and Visits:____

☐ Date of planned administration:____

_______________________________________ Prescriber Signature

_______________________________________ Date

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