HIGHMARK | HIGHMARK

Medication Prior Authorization Form

Fax to 1-866-240-8123

Blood Disorders Request Form

Member Information:

Subscriber's ID Number	Highmark Coverage ☐ MA-PD ☐ PDP	Subscriber's Group Number	
Member's Name		Member's Date of Birth	Member's Phone Number
Member's Address	City	State	Zip Code

Medication Information:

Requested Drug Name		Drug Strength or Dose
Directions		Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ Perioperative
Requested Quantity Per Month	Refills	Ship To (please check one) ☐ Physician's Office ☐ Member's Home Other_____

Provider Information:

Physician's Name	NPI or Tax ID #	Phone	Fax
Address	City	State	Zip Code
DEA (if applicable)	Physician's Signature		Date

Clinical Criteria:

Diagnosis Code	Dx Code Description	
Disease Severity ☐ Mild (5-40%) ☐ Moderate (1%-5%) ☐ Severe (<1%)	Baseline Factor Level Reading (%) Baseline Level: _____%	Member's Actual Body Weight (ABW) & Date Measured _____ kg _____ lb Date:_____
Past History of Inhibitor Development? ☐ Yes ☐ No	Inhibitor Currently Present? If yes—Level? ☐ Yes ☐ No _____ Bethesda Units (BU)	
Has the member undergone Immune Tolerance Induction? ☐ Yes – inhibitor successfully tolerized ☐ No ☐ Yes – failed ITI		Dose calculated using Actual Body Weight (ABW) or Ideal Body Weight (IBW)? ☐ ABW ☐ IBW IBW: _____kg _____lb

Alternatives tried by member (if applicable):

Drug Name (1)	Drug Strength, Dose, and Directions
Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ Perioperative	Documentation of Failure of Therapy
Drug Name (2)	Drug Strength, Dose, and Directions
Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ Perioperative	Documentation of Failure of Therapy

Is the member a candidate for prophylactic therapy?	Yes	No
Is there a management strategy in place?	Yes	No
If this request is for reauthorization, is there clinical documentation that the member's condition is stable on therapy and has not progressed or worsened?	Yes	No
If any bleeding episode occurred during therapy, is there clinical documentation of the bleeding episode occurrence and type of bleeding (e.g., spontaneous bleeds, joint bleeds, etc.)?	Yes	No

Medical Rationale / Reason For Drug Therapy / Treatment Plan:

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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