



## Alaska Medicaid Prior Authorization Request Form Hemophilia/Bleeding Disorder Intake Form – Prescribing/Treatment Plan

Fax this request to: 1-888-603-7696

Questions: Call Magellan Medicaid Administration at 800-331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member, please.

<b>Treatment Plan Prescription Information</b>					
PRODUCT NAME	DOSE/UNITS/Kg	ROUTE	FREQUENCY	QUANTITY	REFILLS
<b>Factor VIII (Recombinant, antibody)</b>					
<input type="checkbox"/> Advate® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> NovoEight® <input type="checkbox"/> Xyntha® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Idelvion® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Kovaltry® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Hemlibra®	Prophylaxis:				
	Bleed:				
<b>Factor IX</b>					
<input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Benefix® <input type="checkbox"/> Mononine® <input type="checkbox"/> Alprolix® <input type="checkbox"/> IDELVION® <input type="checkbox"/> Profilnine® SD <input type="checkbox"/> Bebulin® VH <input type="checkbox"/> Ixinity® <input type="checkbox"/> Rixubis®	Prophylaxis:				
	Bleed:				
<b>Factor XIII</b>					
<input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten® <input type="checkbox"/> Amicar® Tablet <input type="checkbox"/> Amicar® Syrup <input type="checkbox"/> Lysteda™ <input type="checkbox"/> Stimate®	Prophylaxis:				
	Bleed:				
<b>Von Willebrand Products</b>					
<input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Humate P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate®	Prophylaxis:				
	Bleed:				
<b>Inhibitor Therapies</b>					
<input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven®	Prophylaxis:				
	Bleed:				
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____					

Individual preparing form: \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

Date: \_\_\_\_\_

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