



**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 REQUESTED

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

				-					-				
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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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SECTION III: CLINICAL HISTORY

1. Is the prescriber a hematologist? Yes No
2. Is the patient managed by a hemophilia treatment center? Yes No
3. Does the patient have moderately severe to severe congenital factor IX deficiency, confirmed by blood coagulation testing? Yes No
4. Provide clinical information confirming patient has had one or more of the following:
 - a. Use of factor IX prophylaxis (provide therapy and dates): _____
 - b. Life-threatening hemorrhage (provide detail and 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

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Review Date: 06/29/2023





New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
 Hemgenix™ (etranacogene dezaparvovec-drlb)

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY

5. Is the patient negative for factor IX inhibitor titers on initial test or re-test? Yes No
6. Will the Factor IX activity be monitored periodically? Yes No
7. Will the patient be monitored for factor IX inhibitors if bleeding is not controlled? Yes No
8. Will the liver function be assessed after Hemgenix® dose weekly for at least 3 months? Yes No
- a. Attach copy of baseline liver function tests.
9. Does the patient have any of the following: Yes No
- 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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