

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Alhemo[®] (concizumab-mtci)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.
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Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosing:

- SUBQ: 1 mg/kg once on day 1 (loading dose) then 0.2 mg/kg once daily starting on day 2; continue for 4 to 8 weeks, then maintenance dosage is based on plasma concentrations
- Hemophilia A & B – concizumab initial dosage adjustments based on trough plasma concentration (4 to 8 weeks after initiation)

Concizumab plasma concentration	Dosage adjustment (SUBQ)
<200 ng/mL	Increase dose to 0.25 mg/kg once daily
200 to 4,000 ng/mL	Continue 0.2 mg/kg once daily
>4,000 ng/mL	Decrease dose to 0.15 mg/kg once daily

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ☐ Member is ≥ 12 years of age
- ☐ Member's weight is ≥ 25 kg
- ☐ Medication prescribed by a specialist familiar with treating patients with hemophilia (factor VIII or IX deficiency)
- ☐ Female patients of reproductive potential are **NOT** pregnant prior to initiating therapy with concizumab
- ☐ Requested medication concizumab will **NOT** be used in combination with hemophilia bypassing agent prophylaxis (i.e., factor VIIa or anti-inhibitor coagulant complex), immune tolerance induction with clotting factor products (i.e., factor VIII or factor IX concentrates) as prophylactic therapy, Hemlibra[®] (emicizumab-kxwh) in those with hemophilia A as prophylactic therapy, and Hympavzi[®] (marstacimab-hncq) or Qfitlia[®] (fitusiran) in those with hemophilia A or hemophilia B as prophylactic therapy
- ☐ Concizumab will **NOT** be used for the treatment of breakthrough bleeds (**NOTE:** bypassing agents may be administered on an as needed basis for the treatment of breakthrough bleeds in patients being treated with concizumab)
- ☐ Member does **NOT** have a history of, or is on current treatment for inherited or acquired coagulation disorder other than congenital hemophilia
- ☐ Member meets **ONE** of the following diagnosis conditions:
 - ☐ Member has a diagnosis of **Hemophilia A** (congenital factor VIII deficiency) and meets **ALL** the following:
 - ☐ Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing
 - ☐ Member has **NOT** received prior gene therapy for hemophilia A (e.g., Roctavian[®] (valoctocogene roxaparvovec-rvox))
 - ☐ Member meets **ONE** of the following:
 - ☐ Member has a history of life-threatening hemorrhage requiring on-demand use of factor replacement therapy
 - ☐ Member has a history of repeated, serious spontaneous bleeding episodes requiring on-demand use of Factor VIII therapy was required for these serious spontaneous bleeding episodes

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- ☐ Member has a diagnosis of **Hemophilia B** (congenital factor IX deficiency) and meets **ALL** the following:
 - ☐ Diagnosis of congenital factor IX deficiency has been confirmed by blood coagulation testing
 - ☐ Member has **NOT** received prior gene therapy for hemophilia B (e.g., Hemgenix[®] (etranacogene dezaparvovec-drlb), Beqvez[™] (fidanacogene elaparvovec-dzkt))
 - ☐ Member meets **ONE** of the following:
 - ☐ Member has a history of life-threatening hemorrhage requiring on-demand use of replacement therapy
 - ☐ Member has a history of repeated, serious spontaneous bleeding episodes requiring on-demand use of Factor IX therapy was required for these serious spontaneous bleeding episode

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member continues to meet the indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, dosing recommendations, etc. identified in the initial criteria section
- ☐ Member has **NOT** experienced any unacceptable toxicity from the drug (e.g., thromboembolic events, hypersensitivity)
- ☐ Member has demonstrated a beneficial response to therapy (i.e., the frequency of bleeding episodes has decreased from pre-treatment baseline, in severity of bleeding episodes, and/or in the number of spontaneous bleeding events) [**NOTE:** providers must submit well-documented, quantitative assessment of bleeding events since initiating concizumab therapy]
- ☐ Member's concizumab plasma concentration are being monitored and laboratory documentation submitted with request will adhere to the following dose adjustments:
 - ☐ Less than 200 ng/mL: adjust to a once-daily dose of 0.25 mg/kg
 - ☐ 200 to 4,000 ng/mL: continue once-daily dose of 0.2 mg/kg
 - ☐ Greater than 4,000 ng/mL: adjust to once-daily dose of 0.15 mg/kg

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****