Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Roctavian™ (valoctocogene roxaparvovec-rvox)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have severe congenital factor VIII deficiency, confirmed by factor VIII activity <1 IU/dL testing? ☐ Yes ☐ No
2. Have other bleeding disorders been ruled out? ☐ Yes ☐ No
3. Is the patient AAV serotype 5 (AAV5) antibody negative as determined by an FDA-approved or CLIA-compliant test? ☐ Yes ☐ No
4. Does the patient have an active infection (acute or uncontrolled chronic)? ☐ Yes ☐ No
5. Does the patient have significant hepatic fibrosis (stage 3 or 4) or cirrhosis? ☐ Yes ☐ No
6. Is the patient on a stable dose of exogenous factor VIII for prevention of bleeding episodes? ☐ Yes ☐ No
   a. Regimen and start date: _____

(Form continued on next page.)

Fax to DHHS; medication is administered in inpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

Review Date: 01/29/2024

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY

7. Does the patient have a hypersensitivity to mannitol? ☐ Yes ☐ No
8. Has the patient received prior hemophilia adeno-associated virus vector-based gene therapy? ☐ Yes ☐ No
9. Is the patient negative for factor VIII inhibitor titers on initial test or re-test? ☐ Yes ☐ No
10. Is the patient received a bypass agent (e.g. Feiba)? ☐ Yes ☐ No
11. Will the liver function be assessed after Roctavian™ dose according to a facility protocol? ☐ Yes ☐ No
    a. Attach copy of baseline liver function tests.
12. Does the patient have any of the following: ☐ Yes ☐ No
    - Hepatitis B
    - Hepatitis C
    - Non-alcoholic fatty liver disease
    - Chronic alcohol consumption
    - Non-alcoholic steatohepatitis
    - Advanced age
13. If yes to question 12, will the patient have regular liver ultrasounds and testing for alpha-fetoprotein elevation? ☐ Yes ☐ No
14. Attach protocol for post-Roctavian™ monitoring.

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

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Prime THERAPEUTICS™