

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

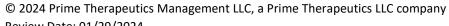
Roctavian™ (valoctocogene roxaparvovec-rvox)

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														
 Does the patient have severe congenital factor VIII deficiency, confirmed by factor VIII activity <1 IU/dL testing? 														
2. Have other bleeding disorders been ruled out?														
3. Is the patient AAV serotype 5 (AAV5) antibody negative as determined by an FDA-approved or CLIA-compliant test?														
4. Does the patient have an active infection (acute or	uncontrolled chronic)?													
5. Does the patient have significant hepatic fibrosis (st	tage 3 or 4) or cirrhosis?													
6. Is the patient on a stable dose of exogenous factor VIII for prevention of bleeding episodes?														
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:											
SEC	TION	III: C	LINIC	CAL HI	STORY																			
7.	7. Does the patient have a hypersensitivity to mannitol?															No								
8.	Has tl	he pa	atient	recei	ved pri	or he	emop	hilia	ader	o-as	soci	iated	virus	vec	tor-b	ased	gene	e ther	apy \hat{i}		Yo	es	No	
9.	Is the	pati	ent n	egativ	e for fa	actor	VIII i	nhibi	itor t	iters	on	initia	l test	or re	e-tes	t?					Ye	es	No	
10.	Is the	pati	ent re	eceive	d a byp	ass a	agent	(e.g	. Feik	oa)?											Ye	es	No	
11.	Will t	he liv	er fu	nctio	n be ass	sesse	d aft	er Ro	octav	ian™	dos	se ac	cordi	ng to	a fa	cility	prot	ocol?	•		Ye	es	No	
	a. A	ttach	сору	of ba	aseline	liver	funct	tion t	tests.															
12.	Does	the p	oatier	nt hav	e any o	f the	follo	wing	g:												Ye	es	No	
	NoClNoAcIf yesfetop	on-a nroni on-a dvan to q rote	ic alco lcoho ced a uestio in ele	ohol c lic ste ge on 12, vatior	ty liver onsump ratohep will the n? ost-Roc	ption patitis e pat	i s ient l				ver	ultra	soun	ds ar	nd tes	sting	for a	llpha-		ļ	∏ Y∈	es	☐ No	
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	-				ition pr							•				•		_			dersta	and	that	
PRESCRIBER'S SIGNATURE:																		DA	ATE:					
Fac	ility w	here	infu	sion to	be pro	ovide	ed:	_																
Me	dicaid	l Pro	vider	Numl	oer of F	acilit	y:	_																

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