State of Oklahoma
Oklahoma Health Care Authority
Factor Replacement Products Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy NPI:_____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:***_____
Pharmacy Name:_____ ***Pharmacist Name:***_____
Prescriber NPI: _____ ***Prescriber Name:*** _____
Specialty: _____ ***Prescriber Phone:***_____ ***Prescriber Fax:*** _____
Fill Date: _____

Clinical Information

1. Diagnosis (ICD-10): _____ Inhibitor : Yes:____ No:_____
2. Factor Replacement Product: _____
3. NDCs to be potentially used throughout year (to be completed by the dispensing pharmacy):
   _____-____-__ _____-____-__ _____-____-__ _____-____-__
   _____-____-__ _____-____-__ _____-____-__ _____-____-__
   _____-____-__ _____-____-__ _____-____-__ _____-____-__
4. Estimate total units to be used per year: _____
5. For members requesting an extended half-life factor product or Obizur® a patient-specific clinically significant reason why current factor product cannot be used (or Feiba® and NovoSeven® if requesting Obizur®) must be provided:
   _____
   _____
   _____
   _____
   _____
6. Has a half-life study been performed? Yes ____ No ____ Date(s) performed: _____
7. For extended half-life factor products was there a significant benefit seen in half-life? Yes___ No:___

❑ I recommend this patient be followed by an OHCA Care Management Nurse.

Prescriber Signature: _____ **Date:** _____

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OHCA Approved – 09/12/2019