



**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER
 AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

Member Information			
Member ID #:		Member Name (Last, First):	
Address:		City, State, Zip:	
DOB:	Sex:	Weight:	Dose:
Date of Service:		Units:	
Primary Diagnosis Code:		HCPCS Code:	
Please fill out completely for all prior authorization requests.			
1. Is the individual 18 years of age or older?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the individual have severe or moderately severe factor IX deficiency ($\leq 2\%$ of normal circulating factor IX)? Please attach test results.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is this treatment being prescribed by, or in consultation with, a hematologist? If yes, please specify: Hematologist Name: _____ Phone Number: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the individual previously received gene therapy for hemophilia B? Please attach provider attestation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Please mark "yes" to all that apply and attach provider attestation: a. The individual is currently using factor IX prophylaxis. b. The individual has a current or history of a life-threatening hemorrhage. c. The individual has a history of repeated, serious, spontaneous bleeding episodes.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has the individual had a negative factor IX inhibitor test (≤ 0.6 Bethesda Units [BU]) within the last 30 days? Please attach test results.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the individual have a history of inhibitors to factor IX? Please attach provider attestation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the individual have serological evidence of HIV1 or HIV2 infection with either CD4+ cell count ≤ 200 mm ³ and/or a viral load >20 copies/mL? Please attach test results.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the individual have an active infection of Hepatitis B virus or Hepatitis C virus? Please attach test results.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is the individual on antiviral therapy for Hepatitis B virus or Hepatitis C virus infection? Please attach provider attestation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Please answer the following questions regarding liver disease: a. Does the individual have a history of significant liver or biliary disease? b. Have all baseline liver health assessments been performed? Please attach provider attestation and all liver health assessments including liver function tests and assessments for liver fibrosis.		<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
12. Will the treating provider continue to monitor the liver function and factor IX activity after gene therapy administration as outlined in the package insert? Please attach provider attestation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Will the treating provider follow all FDA recommendations for dosage, preparation, administration, additional monitoring, and patient education? Please attach provider attestation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Billing Provider Information			
Medicaid Billing Number:		Billing Provider Name:	
Street Address:		City, State, Zip:	
Contact Name:		Contact Telephone Number:	
Contact Fax Number:			
Ordering Provider Information			
Medicaid Billing Number:		Ordering Provider Name:	
Street Address:		City, State, Zip:	
Contact Name:		Contact Telephone Number:	
Contact Fax Number:		Provider Specialty:	
Certification Statement: This is to certify that the requested treatment is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.			
Provider Signature:			Date: