HUSKY Health Program Roctavian® (valoctocogene roxaparvovec-rvox)
Prior Authorization Request Form
Phone: 1.800.440.5071

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:		Primary Diagnosis Code:	

Please fill out completely for all prior authorization requests:		
1. Is the individual 18 years of age or older?	◯Yes	◯No
2. Does the individual have severe hemophilia A as evidenced by endogenous Factor VIII levels ≤ 1 IU/dL? ***Please attach test results.***	◯Yes	◯No
3. Is this treatment being prescribed by, or in consultation with, a hematologist? ***If yes, please specify***: Hematologist Name: _____ Phone Number: _____	◯Yes	◯No
4. Does the individual have pre-existing antibodies to AAV5? ***Please attach test results.***	◯Yes	◯No
5. Does the individual have a platelet count ≥ 100 x 10^9/L? ***Please attach test results.***	◯Yes	◯No
6. Does the individual have a creatinine level < 1.4 mg/dL? ***Please attach test results.***	◯Yes	◯No
7. Has the individual had a negative Factor VIII inhibitor test (≥0.6 Bethesda Units [BU]) within the last 30 days? ***Please attach test results.***	◯Yes	◯No
8. Is the individual currently undergoing treatment with Factor VIII prophylaxis? a. If yes, does the individual have a history of prophylactic Factor VIII use for at least 150 exposure days? ***Please attach signed provider attestation.***	◯Yes ◯Yes	◯No ◯No
9. Does the individual have any history of inhibitors to Factor VIII?	◯Yes	◯No
10. Does the individual have evidence of any of the following (either acute or uncontrolled chronic) active infections? ***Please attach signed provider attestation.***		
a. Acute respiratory infections	◯Yes	◯No
b. Acute hepatitis	◯Yes	◯No
c. Chronic or active hepatitis B	◯Yes	◯No
d. Active hepatitis C, as evidenced by detectable HCV RNA or currently on antiviral therapy	◯Yes	◯No
e. Human Immunodeficiency Virus (HIV) infection	◯Yes	◯No
11. Does the individual have an immunosuppressive disorder? ***Please attach signed provider attestation.***	◯Yes	◯No
12. Does the individual have significant liver disease? ***Please attach signed provider attestation.***	◯Yes	◯No
13. Does the individual have an active malignancy, excluding non-melanoma skin cancer? ***Please attach signed provider attestation.***	◯Yes	◯No
14. Does the individual have a history of thrombosis or thrombophilia? ***Please attach signed provider attestation.***	◯Yes	◯No
15. Does the individual have a known hypersensitivity to mannitol? ***Please attach signed provider attestation.***	◯Yes	◯No
16. Has the individual previously received Roctavian® or any other gene therapy? ***Please attach signed provider attestation.***	◯Yes	◯No
17. Has the individual been counseled on the risks of alcohol consumption after receiving Roctavian® and directed to abstain from alcohol consumption for at least one year following infusion, and limit consumption thereafter? ***Please attach signed provider attestation.***	◯Yes	◯No
18. Will treatment with Factor VIII products for prophylaxis be stopped after Roctavian® infusion achieves adequate Factor VIII levels? ***Please attach signed provider attestation.***	◯Yes	◯No
19. Will the treating provider follow all FDA-approved labeling recommendations for usage, dosage, preparation, administration, monitoring, and patient education? ***Please attach signed provider attestation.***	◯Yes	◯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:

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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: