UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hympavzi (marstacimab)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient 12 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of either of the diseases listed below? ❑ **Yes** ❑ **No**
   - ❑ Hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitor
   - ❑ Hemophilia B (congenital factor IX deficiency) without factor IX inhibitor
3. Is the medication being prescribed by or in consultation with a hematologist for prevention of bleeding episodes? ❑ **Yes** ❑ **No**
4. If the patient has reproductive potential, does the provider attest that the patient is NOT pregnant? ❑ **Yes** ❑ **No**
   a. Pregnancy test chart note page: _____
   b. Has the provider advised the patient to use effective forms of contraception during and for 2 months after the last dose of the treatment? ❑ **Yes** ❑ **No**
   c. Contraception methods: _____
5. Does the patient have at least one of the following:? ❑ **Yes** ❑ **No**
   - ❑ Prophylaxis with Factor VIII or Factor IX clotting agents was not effective
   - ❑ The patient has poor venous access
   - ❑ The patient failed to achieve an adequate trough level while on optimal dose of Factor VIII or Factor IX clotting agent

❑ The patient had serious side effect, FDA labeled contraindication, or hypersensitivity to Factor VIII or Factor IX clotting agent

Provide details: _____

6. If the patient is currently taking prophylactic clotting factor replacement therapy, does the provider attest that the patient will discontinue the clotting factor concentrate before initiating marstacimab?

❑ **Yes** ❑ **No**

7. Does the provider attest that the patient **DOES NOT** have the following? ❑ **Yes** ❑ **No**
   - ❑ History of coronary artery disease
   - ❑ Venous or arterial thrombosis
   - ❑ Ischemic disease

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating a positive clinical response? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- HYMPAVZI is a tissue factor pathway inhibitor (TFPI) antagonist and may increase the risk of thromboembolic complications.
- HYMPAVZI has not been studied in patients with a history of previous thromboembolic events. Interrupt HYMPAVZI prophylaxis if diagnostic findings consistent with thromboembolism occur and manage as clinically indicated.
- If factor VIII or factor IX products are indicated in a patient receiving HYMPAVZI prophylaxis, the minimum effective dose of factor VIII or factor IX according to the product label is recommended.
- HYMPAVZI may cause hypersensitivity reactions (including but not limited to urticaria and pruritus). If HYMPAVZI-treated patients develop a severe hypersensitivity reaction, advise patients to discontinue HYMPAVZI and seek immediate emergency treatment.
- Based on its mechanism of action, HYMPAVZI may cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to the fetus. Advise females of reproductive potential to use effective contraception during treatment with HYMPAVZI and for 2 months after the last dose.
- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date