Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Helixate FS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Helixate FS (FA-PA).

Drug Name (select from list of drugs shown)
Helixate FS (antihemophilic factor (recombinant))

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The preferred product for your patient's health plan is Kogenate FS. Can the patient's treatment be switched to Kogenate FS? Y N

(Please note: Kogenate FS and Helixate FS are the exact same products with different labels and brand names, which are made by the same manufacturer.)

2. Given that Kogenate FS and Helixate FS are the same products, is there a documented clinical reason that the patient must use Helixate FS over Kogenate FS? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S). Y N _____

3.	Has the patient experienced a documented intolerable adverse event to Kogenate FS? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
4.	Is there a documented clinical reason why the patient is not expected to experience the same adverse event with Helixate FS? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date