New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Hemophilia B Gene Therapy

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

SECTION III: CLINICAL HISTORY

1. Is the prescriber a hematologist? ☐ Yes ☐ No
2. Is the patient managed by a hemophilia treatment center? ☐ Yes ☐ No
3. Does the patient have moderately severe to severe congenital factor IX deficiency, confirmed by blood coagulation testing? ☐ Yes ☐ No
4. Provide clinical information confirming patient has had one or more of the following:
   - Use of factor IX prophylaxis (provide therapy and dates): _____
   - Life-threatening hemorrhage (provide detail and dates): _____
   - Repeated, serious spontaneous bleeding episodes (provide detail and dates): _____
5. Is the patient negative for factor IX inhibitor titers on initial test or re-test? ☐ Yes ☐ No
6. Will the Factor IX activity be monitored periodically? ☐ Yes ☐ No
7. Will the patient be monitored for factor IX inhibitors if bleeding is not controlled? ☐ Yes ☐ No

(Form continued on next page.)

Fax to DHHS; medication is administered in inpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

Review Date: 06/03/2026

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY

8. Will the liver function be assessed after gene therapy administered weekly for at least 3 months? ☐ Yes ☐ No
   a. Attach copy of baseline liver function tests.
9. Does the patient have any of the following: ☐ Yes ☐ No
   - Cirrhosis
   - Advanced hepatic fibrosis
   - Hepatitis B
   - Hepatitis C
   - Non-alcoholic fatty liver disease
   - Chronic alcohol consumption
   - Non-alcoholic steatohepatitis
   - Advanced age
10. Attach protocol for post gene therapy monitoring.

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

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