Anti-Hemophilic
Antithrombin III (Recombinant) J7196
Antithrombin III (Human) 1IU J7197
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**NEW START - Start Date:**_______________	☐	**Continuation** (within 365 days)**:** Date of last treatment ________________
☐	Date Requested ____________________		
	Requestor ____________________ Clinic name: ___________________ Phone / Fax		

MEMBER INFORMATION

*Name:_____________________________________ *ID#:_____________________ *DOB:_____________________

PRESCRIBER INFORMATION

*Name:__________________________________ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:______________________

*Address:____ *Fax:________________________

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:___________________________________ Phone:___________________________

*Address:____ Fax:____________________________

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:______)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**____

Diagnosis: ICD10: _________ **Description**: ____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: ____

____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: ________________________________

____

ACKNOWLEDGEMENT

Request By (Signature Required): ____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Coagulation Factors PA

Drug Name(s):

ANTITHROMBIN III (Human) **ANTITHROMBIN III (Recombinant)**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Patient is being treated for ONE of the following purposes:
    a. Treatment and prevention of thromboembolism
    b. Prevention of perioperative and peripartum thromboembolism
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Age Restrictions:

N/A

Prescriber Restrictions:

N/A

FDA Indications:

Antithrombin III (Human/Recombinant):

- Treatment of hereditary antithrombin III deficiency
    - Treatment and prophylaxis of thromboembolic disorder
    - Prophylaxis of perioperative and peripartum thromboembolic disorder

Off-Label Uses:

- Antithrombin III deficiency, Acquired
- Drug resistance, Heparin

Coverage Duration:

Approval will be for 12 months

Other Clinical Consideration:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/4CBAB6/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/72545D/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Antithrombin%20III%20(Human)&UserSearchTerm=Antithrombin%20III%20(Human)&SearchFilter=filterNone&navitem=searchGlobal#

Clinical / CMS Only