Prior Authorization Request
Medicare Part B Form

Anti-Hemophilic
Vonvendi (Von Willebrand Factor, Recombinant)
J7179

*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:_____

*Fax:_____ *Address:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Primary ICD-10 Code(s):_____

*Address:_____ Phone:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Description ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

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

CLINICAL INFORMATION

☐ **Vonvendi (Von Willebrand Factor, Recombinant)**

For New Starts and Initial Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Patient has a diagnosis of Von Willebrand disorder and Hemorrhage

- ☐ Perioperative management of bleeding
- ☐ On-demand treatment or prophylaxis of bleeding episodes

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

☐ Yes ☐ No Does the patient have a hypersensitivity to Von Willebrand Factor or constituents of the product (trisodium citrate dihydrate, glycine, mannitol, trehalose dihydrate, polysorbate 80, and hamster or mouse proteins)?

☐ Yes ☐ No Has the patient had an adequate response or significant improvement while on this medication?

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

_____

ACKNOWLEDGEMENT

Request Completed 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.

UM Criteria

- Approval duration will be 1 year from the date of approval
- Tiering and quantity limits as stated per formulary

• **FAX completed forms with supporting documentation to the appropriate FAX number below:**	
Louisiana	• **Ascension, East Baton Rouge, Livingston, West Baton Rouge & West Feliciana Parishes (615) 869-0040**
Nevada	• **Douglas, Lyon, Storey, Washoe & Carson City Counties (775) 770-3909**
Oregon	• **Douglas: (541) 672-4318** • **Jackson & Josephine: (866) 500-8773** • **Klamath: (541) 882-6914** • **Marion & Polk: SNF & Hospital (503) 485-3220** • **Other Prior Authorizations (503) 581-7422**
Tennessee	• **Bedford, Coffee, Davidson, Rutherford, Sullivan, Washington, Williamson & Wilson Counties (615) 869-0040**

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):
VON WILLEBRAND FACTOR (RECOMBINANT)
VONVENDI

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Patient does not have uncorrected hypocalcemia
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

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:
Vonvendi

- Von Willebrand disorder
  - Hemorrhage - Perioperative management of bleeding
  - Hemorrhage - On-demand treatment
  - Hemorrhage – Prophylaxis – won Willebrand disease type 3 (Severe), receiving on-demand therapy

Off-Label Uses:
N/A

Age Restrictions:
Only approved in adults 18 years of age or older

Other Clinical Consideration:
Pre-existing hypocalcemia must be corrected prior to initiating therapy.

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/A47381/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/9EF8FD/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=931666&contentSetId=100&title=Von+Willebrand+Factor+Recombinant&servicesTitle=Von+Willebrand+Factor+Recombinant&brandName=Vonvendi&UserMdxSearchTerm=Vonvendi&=null#