US Family Health Plan
Prior Authorization Request Form for
Concizumab-mtci (Alhemo)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 12 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have hemophilia A with factor VIII inhibitors OR hemophilia B with factor IX inhibitors?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient concurrently receiving Factor VIII or IX therapy?	☐ Yes Proceed to question **5**	☐ No **Sign and date below**
5. Is the patient concurrently receiving Factor VIII or IX therapy for the treatment of breakthrough bleeding?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[07 Feb 2025]