



## Factor I Prior Authorization

Drug(s) Applied:	Fibryga, RiaSTAP
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### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

- I. Initial Approval Criteria
  - A. **Factor I Deficiency (Acquired or Congenital Fibrinogen Deficiency)** as indicated by chart notes within past 90 days
    1. Requested agent is being used for ONE of the following:
      - a) Patient is currently experiencing a bleed and is out of medication and needs to receive a ONE TIME emergency supply of medication **or**
      - b) Fibrinogen supplementation in bleeding patient or on-demand treatment to control acute bleeding episodes and ALL of the following:
        - (1) Patient has a fibrinogen level of less than 200mg/dL **and**
        - (2) Does NOT have dysfibrinogenemia **and**
        - (3) Prescriber has verified that the patient does NOT have more than 5 on-demand doses on hand **and**
    2. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., hematology)

### Approval Duration:

**One time emergency use:** 1 time

**On-demand treatment:** 3 months

**Policy Owned by:** Curative PBM team