curative

Factor I Prior Authorization Drug List A

Drug(s) Applied:	Fibryga, RiaSTAP

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 Therapy 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