



Physician's Prior Authorization Questionnaire for Stimate®

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Stimate® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug.

1. What is the patient's diagnosis (**Please do not use codes**)? _____

2. Does the patient have hemophilia B? ____Yes ____No
3. Does the patient have von Wildebrand's disease Type IIB? ____Yes ____No
4. Are the Factor VIII levels greater than 5%? ____Yes ____No
5. Does the patient have Factor VIII antibodies? ____Yes ____No

Physician's Signature	Date
Please Print Name	Fax Number
Please Print Physician's Specialty	Phone Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact ABCBS at (501) 378-3392. For your convenience, you may fax your response(s) back to ABCBS at (501) 378-6980.

Sincerely,
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>