HealthPartners

Gene Therapy for Hemophilia B Attestation Form

Member name: Member ID: Date of Birth:

Prescriber:

1. I will provide ongoing assessment of the patient for treatment efficacy following administration of the requested drug, including but not limited to:
    a. Evaluation of factor IX expression; and,
    b. Breakthrough bleeding episodes; and,
    c. Factor IX product utilization; and,
    d. Inhibitor development; and,
2. I will provide documentation to the health plan, not more frequently than quarterly, and not for a period to exceed 3.5 years post-administration of follow-up patient assessment(s), including but not limited to:
    a. Evaluation of factor IX expression; and,
    b. Breakthrough bleeding episodes; and,
    c. Factor IX product utilization; and,
    d. Inhibitor development while the patient is under the care of the prescriber.

Requested administration date: _____ (Please be specific by listing target date.)

Provider signature: _____ Date: _____

Member/Patient:

1. I understand that I am being prescribed a gene therapy for the treatment of hemophilia B; and,
2. I am aware that the drug cost is ~$3,500,000 for a one-time treatment, and additional costs for therapy and monitoring may apply; and,
3. I have received counseling relating to the infusion, and am prepared to receive this therapy as instructed; and,
4. I am highly motivated to achieve a cure and to refrain from activities that might lead to treatment failure; and,
5. I am willing and able to attend all necessary follow-up provider and lab appointments; and,
6. I agree to inform my provider in a timely manner (e.g., 14 days) if I require rescue therapy or am hospitalized for any reason following treatment; and,
7. I am willing to participate in any health plan-initiated outreach to ensure optimal outcomes.

The best number to reach me at during the day is: _____

Member signature: _____ Date: _____