PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Jesduvroq

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Jesduvroq.

Drug Name (select from list of drugs shown)
Jesduvroq Tablets (daprodustat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications or uses that are not Food and Drug Administration (FDA)-approved, or guideline-supported?	Y N
[If yes, no further questions.]	
2. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N

	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 4.]	
3.	Has the patient had a beneficial response to treatment with the requested medication?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 13.]	
	[If no, no further questions.]	
4.	Does the patient have a diagnosis of anemia due to chronic kidney disease?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the patient been receiving dialysis for at least four months?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Is the patient NOT currently being treated with a Erythropoiesis-Stimulating Agent (ESA)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 8.]	
7.	Is the patient's baseline hemoglobin level less than 11.0 grams per deciliter (g/dL)?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 10.]	
	[If no, no further questions.]	
8.	Is the patient being switched from a current Erythropoiesis-Stimulating Agent (ESA) regimen (such as Epogen, Procrit, Retacrit, Aranesp, or Mircera)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Is the patient's on-treatment hemoglobin level less than or equal to 12.0 grams per deciliter (g/dL)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Is the patient receiving iron supplementation therapy, or has been documented to have adequate iron stores to support therapy?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
11.	Is the requested medication being prescribed by, on in consultation with, a nephrologist?	Y N
	[If no, no further questions.]	

12. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
13. Does the patient meet ANY of the following: A) severe hepatic impairment (Child-Pugh Class C), B) uncontrolled hypertension or C) NOT on dialysis?	Y N
[If yes, no further questions.]	
14. Will the requested medication be used as a substitute for transfusion in patients requiring immediate correction of anemia?	Y N
[If yes, no further questions.]	
15. Will the requested medication be used concurrently with strong cytochrome P450 2C8 (CYP2C8) inhibitors (such as gemfibrozil)?	Y N
[If yes, no further questions.]	
16. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date