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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Velsipity

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 Velsipity.

Drug Name (select from list of drugs shown)
Velsipity (etrasimod)

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.	Is the patient experiencing clinical improvement from treatment supported by one of the following outcomes: A) reduction in gastrointestinal signs and symptoms or B) prolonged clinical remission and mucosal healing?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 8.]	
	[If no, no further questions.]	
4.	Does the patient have a diagnosis of moderate to severe ulcerative colitis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the patient had a trial and inadequate response to immunosuppressants, such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Has the patient had a trial and inadequate response, or intolerance to Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Is the patient 18 years of age or older?	Y N
	[If no, no further questions.]	
8.	Has the patient experienced ANY of the following within 6 months of initiation of treatment with the requested medication: A) myocardial infarction, B) unstable angina, C) stroke, D) transient ischemic attack (TIA), E) decompensated heart failure requiring hospitalization, or F) Class III or IV heart failure?	Y N
	[If yes, no further questions.]	
9.	Does the patient have Mobitz type II second-degree or third degree atrioventricular (AV) block, sick sinus syndrome, or sinoatrial block, unless they have a functioning pacemaker?	Y N
	[If yes, no further questions.]	
10.	Will the requested medication be used concurrently with ANY of the following: A) rifampin or B) another biologic ulcerative colitis therapy?	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