JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Abraxane

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Pancreatic adenocarcinoma
   - ❑ Breast cancer
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Cutaneous melanoma
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Primary peritoneal cancer
   - ❑ Kaposi sarcoma
   - ❑ Endometrial carcinoma
   - ❑ Intrahepatic cholangiocarcinoma
   - ❑ Extrahepatic cholangiocarcinoma
   - ❑ Gallbladder cancer
   - ❑ Uveal melanoma
   - ❑ Small bowel adenocarcinoma, including advanced ampullary cancer
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. How is the patient's disease classified?
   - ❑ Unresectable disease
   - ❑ Metastatic disease
   - ❑ Persistent disease
   - ❑ Recurrent disease
   - ❑ Advanced disease
   - ❑ Distant metastatic disease
   - ❑ Other _____
6. Will the requested drug be used as any of the following? ***Indicate ALL that apply.***
   - ❑ As single-agent therapy
   - ❑ In combination with gemcitabine
   - ❑ As single-agent as second-line or subsequent therapy
   - ❑ In combination with carboplatin as second-line or subsequent therapy
   - ❑ None of the above
7. Will the requested drug be used as a paclitaxel or docetaxel substitute due to hypersensitivity reactions or contraindication to standard hypersensitivity premedications?
   - ❑ Yes - Due to hypersensitivity reactions
   - ❑ Yes - Contraindication to standard hypersensitivity premedications
   - ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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