JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Adakveo

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 _____

What is the ICD-10 code? _____

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?

❒ Sickle cell disease (*If checked, go to 2*)

❒ Other, please specify. (*If checked, go to 2*)

2. Is Adakveo being requested for use in reducing the frequency of vasoocclusive crises (VOCs)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is Adakveo being prescribed by or in consultation with a hematologist or specialist in sickle cell disease?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 5*
❒ No, *Continue to 6*

5. Has the patient experienced a reduction in the frequency of vasoocclusive crises, or has the patient maintained a reduction in the frequency of vasoocclusive crises, since initiating therapy with Adakveo?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Has the patient experienced a vasoocclusive crisis (VOC) in the past 12 months?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's sickle cell genotype?

❒ Homozygous hemoglobin S (HbSS) (*If checked, go to 8)*

❒ Sickle beta0-thalassemia (HbSbeta0) (*If checked, go to 8*)

❒ Sickle hemoglobin C (HbSC) (*If checked, go to 11*)

❒ Sickle beta+-thalassemia (HbSbeta+) (*If checked, go to 11*)

❒ Other/Unknown (*If checked, no further questions*)

8. Has the patient experienced, at any time in the past, an inadequate response or intolerance to a trial of hydroxyurea?

❒ Yes, inadequate response (*If checked, go to 11*)

❒ Yes, intolerance (*If checked, go to 11*)

❒ No (*If checked, go to 9*)

9. Does the patient have a contraindication to hydroxyurea?
❒ Yes, *Continue to 11*
❒ No, *Continue to 10*

10. Will the patient be using Adakveo with concurrent hydroxyurea therapy?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

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11. What is the patient's age (in years)?

_____ years (*If checked, no further questions*)

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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