JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Alphanate, Humate-P, Koate-DVI, Wilate

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

Criteria Questions:

1. What drug is being prescribed? ❑ Alphanate ❑ Humate-P ❑ Koate-DVI ❑ Wilate ❑ Other _____
2. What is the diagnosis?
   ❑ Hemophilia A
   ❑ von Willebrand disease (VWD)
   ❑ Acquired hemophilia A
   ❑ Acquired von Willebrand syndrome (AVWS)
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the requested medication prescribed by or in consultation with a hematologist? ❑ Yes ❑ No
5. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to diagnosis section*
6. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ❑ Yes ❑ No
   No further questions

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hemophilia A

7. What is the patient's baseline factor VIII assay level (% activity)? _____ % *If 5% or less, no further questions*
8. Has the patient had an insufficient response to desmopressin? *If Yes, no further questions* ❑ Yes ❑ No
9. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
   If Yes, indicate clinical reason: _____

Section B: von Willebrand Disease

10. What type of von Willebrand disease does the patient have? *If Type 2B or 3, no further questions.*
    ❑ Type 1 ❑ Type 2A ❑ Type 2B ❑ Type 2M ❑ Type 2N ❑ Type 3 ❑ Other _____
11. Has the patient had an insufficient response to desmopressin? *If Yes, no further questions* ❑ Yes ❑ No
12. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
    If Yes, indicate clinical reason: _____

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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