JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Empliciti

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 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Empliciti SGM 2230-A – 04/2023.

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

Criteria Questions:

What is the ICD-10 code? _____

1. What is the patient's diagnosis?

❒ Multiple myeloma, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. Has the patient's multiple myeloma been previously treated?

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. What is the prescribed regimen?

❒ The requested medication in combination with lenalidomide and dexamethasone, *Continue to 6*

❒ The requested medication in combination with bortezomib and dexamethasone, *Continue to 6*

❒ The requested medication in combination with pomalidomide and dexamethasone, *Continue to 7*

❒ Other, please specify. _____, *No Further Questions*

6. Has the patient received at least one prior regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. Has the patient received at least two prior regimens, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?

❒ Yes, *No Further Questions*

❒ No, *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 CVS Caremark or the benefit plan sponsor.

X_____

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

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