GamaSTAN

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the intended use for GamaSTAN?

❒ Prophylaxis of hepatitis A, *Continue to 2*

❒ Prophylaxis of measles (rubeola), *Continue to 5*

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❒ Prophylaxis of varicella (chickenpox), *Continue to 8*

❒ Prophylaxis of rubella, *Continue to 11*

❒ Other, please specify. _____, *No further questions*

2. Was the patient exposed to hepatitis A virus within the past 2 weeks (e.g., household contact, sexual contact, childcare center or classroom contact with an infected person)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is the patient exhibiting clinical manifestation of disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Is the patient at high risk for exposure to hepatitis A virus (examples of populations at high risk for hepatitis A are travelers to and workers in countries of high endemicity of infection and illicit drug users)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Was the patient exposed to measles within the past 6 days?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Has the patient ever received the measles vaccine (e.g., MMR)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient ever had the measles?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Was the patient exposed to varicella within the past 10 days?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the patient at high risk for severe varicella (e.g., immunocompromised, newborn/infant, pregnant woman)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is varicella zoster immune globulin (e.g., Varizig) not currently available?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Was the patient recently exposed to rubella?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the patient currently pregnant?
❒ 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 Priority Partners.

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

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.hopkinshealthplans.org