Gamifant

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? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Primary hemophagocytic lymphohistiocytosis (HLH), *Continue to 2*

❒ Secondary (acquired) hemophagocytic lymphohistiocytosis (HLH) (If checked, *Continue to 2*

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

2. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 4*

❒ No, *Continue to 11*

❒ Unknown, *Continue to 4*

4. Has the diagnosis of primary hemophagocytic lymphohistiocytosis been confirmed by presence of a mutation in any of the following genes? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or laboratory report.

❒ PRF1 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ STX11 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ STXBP2 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ UNC13D ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ None of the above, *Continue to 5*

❒ Unknown, *Continue to 5*

5. Has the diagnosis been confirmed by the presence of at least 5 of the following: a) fever; b) splenomegaly; c) cytopenias affecting at least 2 of 3 lineages in the peripheral blood: hemoglobin less than 9 g/dL (less than 10 g/dL in infants younger than 4 weeks), platelets less than 100,000/microliter, and/or neutrophils less than 1,000/microliter; d) hypertriglyceridemia (fasting triglyceride greater than or equal to 265 mg/dL) or hypofibrinogenemia (less than or equal to 150 mg/dL); e) hemophagocytosis in bone marrow or spleen or lymph nodes or liver with no evidence of malignancy; f) low or absent natural killer (NK) cell activity; g) ferritin level greater than or equal to 500 ng/mL; h) soluble CD25 (soluble IL-2 receptor alpha) level greater than or equal to 2400 U/mL, or above age-adjusted, laboratory-specific normal levels (defined as 2 standard deviation from the mean)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or laboratory report.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Have possible causes of secondary or acquired forms of HLH (e.g., autoimmune disease, persistent infection, malignancy, or loss of inhibitory immune mechanisms) been ruled out?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have refractory, recurrent or progressive disease or is the patient intolerant to conventional HLH therapy?

❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient been evaluated for tuberculosis (TB) risk factors and undergone pretreatment screening for latent TB with the purified protein derivative (PPD) skin test or interferon gamma release assay?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does any of the following apply to the patient?

❒ Patient has a positive TB test result (PPD skin test or interferon gamma) release essay, *Continue to 10*

❒ Patient is at risk for tuberculosis, *Continue to 10*

❒ None of the above, *No Further Questions*

10. Will the patient start prophylactic TB treatment before starting the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❒ 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)**

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