



## Givlaari

### 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*

**Drug Information:**

*Strength/Measure* \_\_\_\_\_ *Units*  ml  Gm  mg  ea  Un

*Directions(sig)* \_\_\_\_\_ *Route of administration* \_\_\_\_\_

*Dosing frequency* \_\_\_\_\_

What is the ICD-10 code? \_\_\_\_\_

**Site of Service Questions:**

A. Indicate the site of service requested:

- Ambulatory Surgical (POS Code 24)
- Off Campus Outpatient Hospital (POS Code 19)
- Office (POS Code 11)
- Home (POS Code 12)
- On Campus Outpatient Hospital (POS Code 22)

B. Is the patient less than 18 years of age?  
 Yes, skip to Clinical Criteria Questions  
 No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

**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. JHHC SOC Givlaari SGM 3418-A – 02/2024.

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**Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.hopkinshealthplans.org**



**ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  Yes, skip to Clinical Criteria Questions  No

- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
**ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? **ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? **ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? **ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?  
**ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.**  Yes  No

**Criteria Questions:**

1. What is the diagnosis?  
 Acute hepatic porphyria, *Continue to 2*  
 Other, please specify. \_\_\_\_\_, *Continue to 2*
2. Is the patient currently receiving treatment with the requested medication?  
 Yes, *Continue to 8*  
 No, *Continue to 3*
3. Is the patient actively symptomatic?  
 Yes, *Continue to 4*  
 No, *Continue to 4*  
 Unknown, *Continue to 4*
4. Has the patient been tested for porphobilinogen (PBG) in the urine confirmed by a PBG quantitative, random urine test? **ACTION REQUIRED:** If Yes, attach supporting chart note(s).  
 Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 5*  
 No, *Continue to 6*  
 Unknown, *Continue to 6*

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5. Is the porphobilinogen level above lab reference range? **ACTION REQUIRED:** If Yes, attach supporting chart note(s). **ACTION REQUIRED:** Submit supporting documentation

Yes, *No Further Questions*

No, *Continue to 6*

6. Has the patient been tested for a plasma or fecal porphyrin level? **ACTION REQUIRED:** If Yes, attach supporting chart note(s).

Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 7*

No, *Continue to 7*

Unknown, *Continue to 7*

7. Is the plasma or fecal porphyrin level above lab reference range? **ACTION REQUIRED:** If Yes, attach supporting chart note(s). **ACTION REQUIRED:** Submit supporting documentation

Yes, *No Further Questions*

No, *No Further Questions*

8. Is the patient receiving benefit from therapy (e.g., reduction in porphyria attacks that required hospitalizations, urgent healthcare visit, or intravenous hemin administration)?

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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