JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Hemgenix

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 _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Hemgenix SGM 5680-A – 07/2023.

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

Criteria Questions:

1. What is the diagnosis?

❒ Hemophilia B (congenital Factor IX deficiency), *Continue to #2*

❒ Other, *Continue to #2*

2. Is the patient 18 years of age or older?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Will the requested medication be prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Does the patient have a negative Factor IX inhibitor test result within the past 30 days? ***ACTION REQUIRED****: If 'Yes', please attach lab results showing absence of Factor IX inhibitors*

❒ Yes, *Continue to #6*

❒ No, *Continue to #5*

5. Does the patient have a positive Factor IX inhibitor test result within the past 30 days, followed by a negative test result within two weeks of the initial positive result? ***ACTION REQUIRED****: If 'Yes', please attach lab results showing absence of Factor IX inhibitors*

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Has the patient previously received gene therapy treatment?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Does the patient have severe or moderately severe Factor IX deficiency (≤2% of normal circulating Factor IX)? ***ACTION REQUIRED****: If 'Yes', please attach chart notes, medical records or lab tests confirming severe to moderately severe Factor IX deficiency (≤2% of normal circulating Factor IX)*

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Is the patient currently using Factor IX prophylactic therapy? ***ACTION REQUIRED****: If 'Yes', please attach chart notes or medical records supporting current use of Factor IX prophylactic therapy*

❒ Yes, *No Further Questions*

❒ No, *Continue to #9*

9. Does the patient have a current or a history of a life-threatening hemorrhage? ***ACTION REQUIRED****: If 'Yes', please attach chart notes or medical records supporting current or past life-threatening hemorrhage*

❒ Yes, *No Further Questions*

❒ No, *Continue to #10*

Send completed form to: Priority Partners Fax: 1-866-212-4756

10.Does the patient have a history of repeated, serious spontaneous bleeding episodes? ***ACTION REQUIRED***: If 'Yes', please attach chart notes or medical records supporting history of repeated, serious spontaneous bleeding episodes

❒ 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