JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Ixempra

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 _____

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Breast cancer (If checked, go to 2)
❒ Other, please specify. _____ (If checked, go to 2)

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.jhhc.com

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

❒ Yes (If checked, go to 3)
❒ No, (If checked, go to 4)

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes (If checked, *no further Questions*)
❒ No (If checked, *no further questions*)

4. Will the requested medication be used in one of the following regimens?

❒ As a single agent (If checked, go to 5)

❒ In combination with trastuzumab (If checked, go to 7)

❒ In combination with capecitabine (If checked, go to 9)
❒ Other, please specify. _____ (If checked, *no further questions*)

5. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease (If checked, go to 6)

❒ Recurrent disease (If checked, go to 6)

❒ Metastatic disease (If checked, go to 6)

❒ No response to preoperative systemic therapy (If checked, go to 6)
❒ Other, please specify. _____ (If checked, go to 6)

6. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2-positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ HER2-negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
❒ Unknown (If checked, *no further questions*)

7. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease (If checked, go to 8)

❒ Metastatic disease (If checked, go to 8)

❒ No response to preoperative systemic therapy (If checked, go to 8)
❒ Other, please specify. _____ (If checked, go to 8)

8. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2-positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ HER2-negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
❒ Unknown (If checked, *no further questions*)

9. What is the clinical setting in which the requested medication will be used?

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❒ Locally advanced disease (If checked, go to 10)

❒ Metastatic disease (If checked, go to 10)
❒ Other, please specify. _____ (If checked, go to 10)

10. Has the patient failed therapy with an anthracycline and a taxane?

❒ Yes (If checked, go to 12)
❒ No (If checked, go to 11)

11. Does the patient have cancer that is taxane resistant and for which further anthracycline therapy is contraindicated?

❒ Yes (If checked, go to 12)

❒ No (If checked, go to 12)

12. Does the patient have an aspartate aminotransferase (AST) or an alanine aminotransferase (ALT) level greater than 2.5 times the upper limit of normal (ULN) or a bilirubin greater than one time the ULN?

❒ Yes (If checked, *no further questions*)

❒ No (If checked, *no further questions*)
❒ Unknown (If checked, *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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