JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

# Luxturna

## 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* _____

**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**

**Criteria Questions:**

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Biallelic RPE65 mutation-associated retinal dystrophy (*If checked, go to 2*)
❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is there confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Please indicate which of the following genetic tests was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations. ***ACTION REQUIRED***: Attach genetic test results (single gene test or multi gene panel test) confirming a genetic diagnosis of pathogenic/likely pathogenic biallelic RPE65 gene mutations.

❒ Single gene panel test (*If checked, go to 4)*

❒ Multi gene panel test (*If checked, go to 4*)
❒ None of the above (*If checked, go to 4*)

4. Are the RPE65 gene mutations classifications based on the current American College of Medical Genetics and Genomics (ACMG) standards and guidelines for the interpretation of sequence variants?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Please provide the date of the genetic test.

❒ Date: _____MM/DD/YY (*If checked, go to 6*)
❒ Unknown (*If checked, go to 6*)

6. Has pathogenicity of the RPE65 mutations been affirmed within the last 12 months?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's age?

❒ Less than 12 months of age (*If checked, go to 8*)

❒ 12 months to 64 years of age (*If checked,* go to 8)
❒ 65 years of age or older (*If checked, go to 8*)

8. Which of the following test(s) was performed to confirm that the patient has viable retinal cells in each eye to be treated?

❒ Optical coherence tomography (OCT) (*If checked, go to 9*)

❒ Ophthalmoscopy (*If checked, go to 9*)

❒ Optical coherence tomography (OCT) and ophthalmoscopy (*If checked, go to 9*)

❒ None of the above (*If checked*, *go to 9*

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

9. Does the patient have an area of the retina within the posterior pole of greater than 100 micrometer thickness shown on optical coherence tomography (OCT)?

❒ Yes (*If checked, go to 12*)

❒ No (*If checked, go to 10*)
❒ Unknown (*If checked, go to 10*)

10. Within the posterior pole, how many disc areas of the retina are without atrophy or pigmentary degeneration?

❒ 3 or more (*If checked, go to 12*)

❒ Less than 3 (*If checked, go to 11*)
❒ Unknown (*If checked, go to 11)*

11. Is the patient's remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent?

❒ Yes (*If checked, go to 12*)

❒ No (*If checked, go to 12*)
❒ Unknown (*If checked, go to 12*)

12. Has the patient had the requested drug in the past?
❒ Yes, *Continue to 13*
❒ No, *No Further Questions*

13. Please select the eye which was treated in the past.

❒ Right eye (*If checked, go to 14*)

❒ Left eye (*If checked, go to 15*)
❒ Both eyes (*If checked, no further questions*)

14. Is this request for a right eye treatment?

❒ Yes, right eye (*If checked, no further questions*)
❒ No, left eye (*If checked, no further questions)*

15. Is this request for a left eye treatment?

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

❒ No, right eye (*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)**

**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**