# Obizur

## 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*_____

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

 Obizur SGM 1948-A – 04/2023.

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

**Criteria Questions:**

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Acquired hemophilia A, *Continue to 2*

❒ Other, please specify. _____, *No further questions*

2. Is the requested medication prescribed by or in consultation with a hematologist?

❒ 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**