JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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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 patient's diagnosis?

❒ Breast cancer (If checked, go to 2)

❒ Colorectal cancer, including appendiceal adenocarcinoma (If checked, go to 2)

❒ Salivary gland tumors (If checked, go to 2)

❒ Hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, go to 2)

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

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

❒ Yes (If checked, go to 3)

❒ No (If checked, go to 6)

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

❒ Yes (If checked, go to 4)

❒ No (If checked, go to 4)

4. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) treatment of breast cancer (If checked, go to 5)

❒ Adjuvant treatment of breast cancer (If checked, go to 5)

❒ Treatment of recurrent breast cancer (If checked, *no further questions*)

❒ Treatment of metastatic breast cancer (If checked, *no further questions*)

❒ Treatment of breast cancer with no response to preoperative systemic therapy (If checked, *no further questions*)

❒ Treatment of colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, *no further questions*)

❒ Treatment of salivary gland tumor (If checked, *no further questions*)

❒ Treatment of hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

5. How many months has the patient received therapy with the requested medication?

_____ months (*no further questions*)

6. What is the patient's diagnosis?

❒ Breast cancer (If checked, go to 7)

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 14)

❒ Salivary gland tumor (If checked, go to 20)

❒ Hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, go to 23)

7. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please 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, go to 8)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)

❒ Unknown (If checked, go to 8)

8. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) therapy (If checked, go to 9)

❒ Adjuvant therapy (If checked, go to 10)

❒ Treatment of recurrent disease (If checked, go to 13)

❒ Treatment of metastatic disease (If checked, go to 13)

❒ Treatment of breast cancer with no response to preoperative systemic therapy (If checked, go to 13)

❒ Other, please specify. _____ (If checked, *no further questions*)

9. Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?

❒ Yes (If checked, go to 11)

❒ 1 month (If checked, go to 11)

10. Is the disease either node-positive or at high risk for recurrence?

❒ Yes (If checked, go to 11)

❒ 1 month (If checked, go to 11)

11. Will the requested drug be used in combination with trastuzumab and chemotherapy?

❒ Yes (If checked, go to 12)

❒ No (If checked, go to 12)

12. Please indicate how many months of therapy with the requested drug the patient has previously been treated with:

_____ months or greater (*no further questions*)

13. Will the requested drug be used in combination with trastuzumab?

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

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

14. Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? ***ACTION REQUIRED***: If Yes, Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 15)

❒ No (If checked, go to 15)

❒ Unknown (If checked, go to 15)

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15. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED***: If Yes, Please attach chart note(s) or test results of RAS and BRAF mutation status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 16)

❒ No (If checked, go to 16)

❒ Unknown (If checked, go to 16)

16. Has the patient previously been treated with a HER2 inhibitor?

❒ Yes (If checked, go to 17)

❒ No (If checked, go to 17)

17. Will the requested drug be used in combination with trastuzumab?

❒ Yes (If checked, go to 18)

❒ No (If checked, go to 18)

18. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?

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

❒ No (If checked, go to 19)

19. Is the patient appropriate for intensive therapy?

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

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

20. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please 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, go to 21)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)

❒ Unknown (If checked, go to 21)

21. Does the patient have recurrent disease?

❒ Yes (If checked, go to 22)

❒ No (If checked, go to 22)

22. Will the requested drug be used in combination with trastuzumab?

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

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

23. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please 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, go to 24)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 24)

❒ Unknown (If checked, go to 24)

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24. What is the clinical setting in which the requested drug will be used?

❒ Unresectable disease (If checked, go to 25)

❒ Metastatic disease (If checked, go to 25)

❒ Other, please specify. _____ (If checked, go to 25)

25. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 26)

❒ Subsequent treatment (If checked, go to 26)

26. Will the requested drug be used in combination with trastuzumab?

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

❒ No (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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