JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Ryplazim

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

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Plasminogen deficiency type 1 (hypoplasminogenemia), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is this request for continuation of therapy?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Has the patient experienced benefit from therapy as evidenced by disease stability or disease improvement (e.g., improvement in lesion number and/or size, absence of new lesion development, improvement in respiratory function, increased quality of life)? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes, lab reports) documenting disease stability or improvement.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the patient's plasminogen activity level at baseline? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes, lab reports) documenting a baseline plasminogen activity level.

❒ 45% or less, *Continue to 5*

❒ Greater than 45%, *Continue to 5*

❒ Unknown, *Continue to 5*

5. Does the patient have a documented history of lesions and symptoms consistent with a diagnosis of plasminogen deficiency type 1 (e.g., ligneous conjunctivitis, ligneous gingivitis or gingival overgrowth, vision abnormalities, respiratory distress and/or obstruction, abnormal wound healing)? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes, lab reports) documenting a history of lesions and symptoms consistent with diagnosis.

❒ 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)**

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