# Scenesse

## 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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

**Drug Information:**

*Strength/Measure* _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)* _____*Route of administration* _____
*Dosing frequency* _____

What is the ICD-10 code? _____

**Criteria Questions:**

1. What is the patient's diagnosis?

❒ Erythropoietic protoporphyria, *Continue to 2*

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

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

**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.hopkinshealthplans.org**

3. What is the patient's age?

❒ 18 years of age or older, *Continue to 4*

❒ Less than 18 years of age, *Continue to 4*

4. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the patient's age?

❒ 18 years of age or older, *Continue to 6*

❒ Less than 18 years of age, *Continue to 6*

6. Has the patient been tested for protoporphyrin levels in peripheral red blood cells? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) confirming test for protoporphyrin levels in peripheral red blood cells.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 7*

❒ No, *Continue to 7*

❒ Unknown, *Continue to 7*

7. Is the patient's protoporphyrin level above the lab reference range? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) confirming protoporphyrin level.
❒ Yes, above lab reference range ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ No, within or below lab reference range, *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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