JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Sevenfact

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?

❒ Hemophilia A, *Continue to 2*

❒ Hemophilia B, *Continue to 2*

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

2. Does the patient have inhibitors?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. What is the patient's age (in years)?

❒ Less than 12 years old, *Continue to 4*

❒ Greater than or equal to 12 years old, *Continue to 4*

4. Is the request for continuation of therapy?

❒ Yes, *Continue to 6*

❒ No, *Continue to 5*

5. At any point in time, has the patient had an inhibitor titer greater than or equal to 5 Bethesda units per milliliter (BU/mL)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?

❒ 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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