JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Vidaza [azacitidine]

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 _____

Criteria Questions:

A. What is the prescribed drug? ❑ Vidaza ❑ azacitidine ❑ Other _____

B. What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Myelodysplastic syndrome (MDS) *(If checked, go to 2*)

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❒ Acute myeloid leukemia (AML) (*If checked, go to 2*)

❒ Accelerated phase or blast phase myelofibrosis (*If checked, go to 2*)

❒ Blastic plasmacytoid dendritic cell neoplasm (BPDCN) (*If checked, go to 4*)

❒ Myelodysplastic syndrome (MDS)/Myeloproliferative Neoplasms (MPN) Overlap Neoplasms (i.e. chronic myelomonocytic leukemia (CMML), juvenile myelomonocytic leukemia (JMML), BCR-ABL negative atypical chronic myeloid leukemia (aCML), MDS/MPN with neutrophilia, unclassifiable MDS/MPN, or MDS/MPN with ring sideroblasts and thrombocytosis) (*If checked, go to 2*)

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

2. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *No Further Questions*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 5*
❒ No, *Continue to 6*

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Does the patient have relapsed or recurrent disease?
❒ Yes, *Continue to 8*
❒ No, *Continue to 7*

7. Is the requested drug being used for systemic disease with palliative intent?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Will the requested medication be used in combination with venetoclax (Venclexta)?
❒ 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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
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