JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Vonvendi

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?

❒ von Willebrand disease (VWD), *Continue to 2*

❒ Other, please specify. _____, *No further questions*

2. Is the requested medication prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to 8*

❒ No, *Continue to 4*

4. What type of von Willebrand disease does the patient have?

❒ Type 1, *Continue to 5*

❒ Type 2A, *Continue to 5*

❒ Type 2B, *No further questions*

❒ Type 2M, *Continue to 5*

❒ Type 2N, *Continue to 5*

❒ Type 3, *No further questions*

❒ Other, please specify. _____, *No further questions*

5. Has the patient had an insufficient response to desmopressin?

❒ Yes, *No Further Questions*

❒ No, *Continue to 6*

6. Is there a clinical reason for not trying desmopressin first?

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. What is the reason? Please indicate the clinical reason for not trying desmopressin first.

❒ Age less than 2 years, *No further questions*

❒ Pregnancy, *No further questions*

❒ Fluid/electrolyte imbalance, *No further questions*

❒ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No further questions*

❒ Predisposition to thrombus formation, *No further questions*

❒ Trauma requiring surgery, *No further questions*

❒ Life-threatening bleed, *No further questions*

❒ Contraindication or intolerance to desmopressin, *No further questions*

❒ Severe type 1 VWD, *No further questions*

❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No further questions*

❒ Other, please specify. _____, *No further questions*

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8. 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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