PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Brilinta - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Brilinta - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Brilinta (ticagrelor)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Is the patient showing continued tolerance and clinical benefit? Y N _____

[Note: Documentation must be submitted.]

	[No further questions.]		
3.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
4.	Will the patient be using Brilinta with a daily maintenance dose of aspirin 75mg to 100mg?	Y N	
	[If no, then no further questions.]		
5.	Does the patient have any of the following: A) Clinically significant anemia, B) Peptic ulcer disease (PUD) with active bleeding, or other predisposition for increased bleeding risk, C) History of intracranial hemorrhage, D) Concurrent use with another P2Y12 platelet inhibitor?	Y N	
	[If yes, then no further questions.]		
6.	Does the patient have a diagnosis of acute coronary syndrome (ACS) [Unstable angina, acute non-ST elevation myocardial infarction (NSTEMI), or acute ST elevation myocardial infarction (STEMI)]?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then skip to question 9.]		
7.	Does treatment include percutaneous coronary intervention (PCI)?	Y N	
	[If no, then no further questions.]		
8.	Has the patient experienced an inadequate treatment response or intolerance to prasugrel OR is a trial not applicable?	Y N	
	[Note: Documentation must be submitted.] \ [Note: Trial is not applicable if the patient has history of stroke, transient ischemic attack or active bleeding, or if the patient is 75 years of age or older.]		
	[No further questions.]		
9.	Does the patient have a history of myocardial infarction?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then skip to question 12.]		
10.	Does the patient have at least one of the following risk factors: A) Patient is 65 years of age or older, B) Diagnosis of diabetes requiring medication, C) History of a second MI in the past, D) Evidence of multivessel coronary artery disease (CAD), E) Creatinine clearance less than 60mL/min?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
11.	Has the patient experienced an inadequate treatment response or intolerance to clopidogrel OR is a trial not applicable?	Y N	
	[Note: Documentation must be submitted.] \ [Note: Trial is not applicable if the patient is unable to use clopidogrel due to being identified as a cytochrome P450 (CYP) 2C19 poor metabolizer (genetic testing results required).]		

[No further questions.]	
12. Does the patient have the diagnosis of coronary artery disease (CAD) without myocardial infarction (MI) or stroke?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
13. Does the patient have a history of percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG)?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
14. Has the patient experienced an inadequate treatment response or intolerance to clopidogrel OR is a trial not applicable?	Y N
[Note: Documentation must be submitted.] \ [Note: Trial is not applicable if the patient is unable to use clopidogrel due to being identified as a cytochrome P450 (CYP) 2C19 poor metabolizer (genetic testing results required).]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date