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

JOHNS HOPKINS
HEALTH PLANS

9/9/2026 <%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS
Brinsupri - 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 Brinsupri - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Brinsupri (brensocatib)

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 there clinical documentation showing the patient has had a beneficial response to treatment, evidenced by at least ONE of the following: A) Reduction in the number of exacerbations, B) Reduction in signs/symptoms, C) Preservation of lung function?	Y N
	[Note: Documentation must be submitted.]	
	[No further questions.]	
3.	Does the patient have a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) supported by positive high resolution computed tomography (CT) scan?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
4.	Is the requested drug being prescribed for any indications that are not FDA-approved or guideline-supported?	Y N
	[If yes, then no further questions.]	
5.	Is the patient a current smoker?	Y N
	[If yes, then no further questions.]	
6.	Is the patient 12 years of age or older?	Y N
	[If no, then no further questions.]	
7.	Does the patient have ALL of the following signs and symptoms associated with bronchiectasis: A) Cough most days of the week lasting greater than 3 months, B) Production of mucopurulent sputum most days of the week lasting greater than 3 months, C) Recurrent respiratory tract infections?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
8.	Is the patient 18 years of age or older?	Y N
	[If yes, then skip to question 10.]	
9.	Has the patient experienced one or more pulmonary exacerbation requiring systemic antimicrobial therapy in the previous 12 months?	Y N
	[Note: Documentation must be submitted.]	
	[If yes, then skip to question 11.]	
	[If no, then no further questions.]	
10.	Has the patient experienced two or more pulmonary exacerbations requiring systemic antimicrobial therapy in the previous 12 months?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	

11. Will the patient continue to use standard airway clearance therapies, as well as inhaled medications and oral antibiotics as clinically appropriate?	Y N
[If no, then no further questions.]	
12. Does the prescriber attest that respiratory symptoms are not driven primarily by chronic obstructive pulmonary disease or asthma?	Y N

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