

Prior Authorization
JOHNS HOPKINS HEALTH PLANS Chenodal 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 Chenodal Priority Partners MCO.

Drug Name (select from list of drugs shown) Chenodal (chenodiol)

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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
2. Has the patient been diagnosed with calcified (radiopaque) or radiolucent bile pigment stones?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	

3. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 yes, skip to question 9.]	
4. Does the patient have a diagnosis of radiolucent cholesterol gallstones, with evidence supporting a well-opacifying gallbladder?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Is the patient not a selective surgery candidate due to having an increased risk for surgical complications because of systemic disease or age?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Has the patient had trial and inadequate response, intolerance, or contraindication to ursodiol?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
8. Is the patient pregnant or may become pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
9. Has the patient obtained partial or complete dissolution of stones?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Has the patient experienced unacceptable toxicity while taking the requested medication?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
11. Is the patient pregnant or may become pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is 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