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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Fertility Preservation - 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 Fertility Preservation - Priority Partners MCO.

Drug Name
(specify drug) _____

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. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2. Will the requested medication be used for fertility preservation? Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

3.	Is the prescriber, or has the prescriber consulted with, a reproductive endocrinologist?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Will the requested medication be used for ovarian tissue preservation?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 6.]	
5.	Is the patient of prepubertal age or has insufficient time for oocyte retrieval for ovarian tissue cryopreservation?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 7.]	
	[If no, no further questions.]	
6.	Is the patient of reproductive age between puberty and menopause?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Will the requested medication be used as part of fertility preservation services due to the patient having fertility impairment due to at least ONE of the following: A) Surgery, B) Radiation, C) Chemotherapy IV, or D) medical treatment or intervention that affects reproductive organs or processes (provider will need to provide an explanation of the treatment or intervention)?	Y 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