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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Filsuvez - 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 Filsuvez - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Filsuvez (birch triterpenes)

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. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? 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 yes, skip to question 11.]

2. Does the patient have a diagnosis of epidermolysis bullosa (EB) simplex?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
3. Does the patient have a diagnosis of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
4. Does the patient have a current diagnosis or history of squamous cell carcinoma?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
5. Does the patient have at least one cutaneous wound that possesses BOTH of the following characteristics: A) A partial-thickness of 10 to 50 cm^2 in surface area, AND B) Has been present for 21 days to 9 months?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
6. Does the patient have an active infection?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
7. Will the requested medication be used concurrently with gene therapy regimen for treatment of epidermolysis bullosa (EB), such as Vyjuvek (beremagene geperpavec-svdt topical gel)?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
8. Will the requested medication be used for any indications that are not FDA-approved or guideline-supported?	Y N	
[If yes, no further questions.]		
9. Is the requested medication being prescribed by or in consultation with a dermatologist or provider with experience in treating epidermolysis bullosa?	Y N	
[If no, no further questions.]		
10. Is the patient 6 months of age or older?	Y N	
[No further questions.]		
11. Is there clinical documentation showing beneficial response to treatment evidenced by BOTH of the following: A) The treated wound has not completely closed, AND B) The wound size has decreased from baseline?	Y N	
NOTE: Submission of medical records is required.		

[If no, no further questions.]		
12. Does the patient have a diagnosis of epidermolysis bullosa (EB) simplex?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
13. Does the patient have a current diagnosis or history of squamous cell carcinoma?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
14. Will the requested medication be used concurrently with gene therapy regimen for treatment of epidermolysis bullosa (EB), such as Vyjuvek (beremagene geperpavec-svdt topical gel)?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
15. Will the requested medication be used for any indications that are not FDA-approved or guideline-supported?	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