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
Harliku - 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 Harliku - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Harliku (nitisinone)

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 other uses that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

NOTE: Submission of medical records is required.

	[If yes, no further questions.]
2.	Will the requested medication be used concurrently with another nitisinone product? Y N
	[If yes, no further questions.]
3.	Will the requested doses exceed the maximum total daily dosage approved by Food and Drug Administration (FDA)? Y N
	NOTE: Submission of medical records is required.
	[If yes, no further questions.]
4.	Is the patient less than 18 years of age? Y N
	[If yes, no further questions.]
5.	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 no, skip to question 7.]
6.	Does the patient have documentation showing a beneficial response to treatment as evidence by either of the following: A) Reduced urinary homogentisic acid (HGA) levels, or B) Improvement in joint symptoms? Y N
	NOTE: Submission of medical records is required.
	[No further questions.]
7.	Does the patient have a diagnosis of alkaptonuria (AKU)? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
8.	Has the diagnosis been supported by at least one of the following: A) Genetic testing showing biallelic pathogenic or likely pathogenic variants in the homogentisate 1,2-dioxygenase (HGD) gene, or B) Elevated levels of homogentisic acid (HGA) in the urine, evidenced as greater than 0.4 grams per 24 hours ? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
9.	Has the patient had a baseline ophthalmologic examination including slit-lamp examination completed prior to treatment? 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