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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Insulin Products - 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 Insulin Products - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Other, Please specify

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 the patient showing adequate response? Y N _____

[Note: Documentation must be submitted.]

	[No further questions.]		
3.	Is this request for short-acting insulin?	Y N	
	[If no, then skip to question 6.]		
4.	Does the patient have the diagnosis of Type 1 or Type 2 diabetes?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
5.	Has the patient had trial and inadequate response with optimized dosing of formulary Admelog SoloStar or vial?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
6.	Is this request for long-acting insulin?	Y N	
	[If no, then no further questions.]		
7.	Does the patient have the diagnosis of Type 1 or Type 2 diabetes?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
8.	Does the patient have a documented trial and inadequate response with optimized dosing of formulary Basaglar?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
9.	Is the request for Toujeo?	Y N	
	[If no, then no further questions.]		
10.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
11.	Has documentation been provided showing that the member's fasting blood sugars have not been able to be controlled with an adequate trial of insulin glargine 100 units/mL?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
12.	Is the patient using a minimum of 100 units of insulin glargine per day?	Y N	
	[If no, then no further questions.]		
13.	Has documentation been provided showing the patient has been counseled regarding the risk of dosing errors with this higher concentrated insulin product?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
14.	Is Toujeo being prescribed for any of the following: A) Patient or prescriber's preference for Toujeo, B) Patient or	Y N	

prescriber's desire for a smaller injection volume, C) History of non-compliance with previous insulin therapy?

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