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

Kygevvi Oral Powder - 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 Kygevvi Oral Powder - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Kygevvi (doxecitine-doxribtimine)

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.	Does the patient have a history of liver disease or liver function tests (alanine transaminase [ALT], aspartate transaminase [AST], or total bilirubin) greater than or equal two times the upper limit of normal at baseline?	Y N
	[If yes, no further questions.]	
3.	Does the patient have renal insufficiency requiring dialysis?	Y N
	[If yes, no further questions.]	
4.	Does the patient have severe end-organ hypo-perfusion syndrome secondary to cardiac failure resulting in lactic acidosis?	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.	Is there documentation showing that the patient had a beneficial response to treatment, evidenced by an improvement or stabilization in any of the following: A) Motor function (e.g., 6-minute walk test [6MWT], Motor Function Measure [MFM] 20 or MFM 30), B) Pulmonary function, or C) Ability to meet growth and developmental milestones?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
7.	Does the patient have a diagnosis of thymidine kinase 2 deficiency (TK2d) with genetic confirmation of pathogenic TK2 variants?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has the patient experienced symptom onset on or before 12 years of age?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Does the patient have any other genetic disease, polygenic disease, or concurrent inborn error of metabolism?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, no further questions.]	

10. Have baseline liver transaminases (alanine transaminase [ALT], aspartate transaminase [AST]) and total bilirubin levels have been measured prior to starting 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