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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Mayzent - 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 Mayzent - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Mayzent (siponimod)

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 14.]

2. Does the patient have a diagnosis of relapsing remitting multiple sclerosis (RRMS) confirmed by MRI?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 5.]		
3. Does the patient have a diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 5.]		
4. Does the patient have a history of clinically isolated syndrome (CIS) confirmed by MRI?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
5. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
6. Has the patient undergone testing of CYP2C9 genotype?	Y N	
[If no, no further questions.]		
7. Does the patient have genotype *1/*1, *1/*2, or *2/*2?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 10.]		
8. Does the patient have genotype *1/*3 or *2/*3?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
9. Will the dosing for Mayzent be adjusted according to the genotype?	Y N	
[If no, no further questions.]		
10. Has the patient experienced a myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure within 6 months of the prior authorization request?	Y N	
[If yes, no further questions.]		
11. Does the patient have Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, without a functioning pacemaker?	Y N	
[If yes, no further questions.]		
12. Does the patient have a documented trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		

13. Does the patient have a documented trial and inadequate response to either Tecfidera or Gilenya?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
14. Has the patient shown an adequate response 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