



10/17/2025

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Miplyffa - 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 Miplyffa - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Miplyffa (arimoclomol)

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 indications that are not Food and Drug Administration (FDA)-approved or guideline-supported?

Y N

[If yes, no further questions.]

2. Will the requested medication concurrently be used with Aqneursa (levacetylleucine)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
3. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 6.]	
4. Is there documentation demonstrating patient has experienced a positive clinical response, evidenced by stabilization, slowed progression, or improvement in Niemann-Pick disease type C (NPC) symptoms from baseline (motor function, swallowing, and speech/cognitive features) supported by a change in Rescored 4-Domain Niemann-Pick disease Type C Clinical Severity Scale (R4DNPCSS) score?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Will the patient continue to take the requested medication in combination with miglustat?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
6. Has the documentation been submitted showing a diagnosis of Niemann-Pick disease type C (NPC), confirmed by genetic testing showing biallelic pathogenic variants in either the NPC1 or NPC2 gene?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Does the patient have one or more neurological manifestations of NPC, such as loss of motor function, swallowing, or speech and cognitive impairment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Dose the patient have a baseline score on the rescored 4-domain NPC Clinical Severity Scale (R4DNPCSS)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is there documentation that patient can walk either independently or with assistance?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

10. Is there documentation that prescriber has confirmed that the requested medication will be taken in combination with miglustat?

Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

11. Is the patient 2 years of age or older?

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