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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Mytesi - 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 Mytesi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Mytesi (crofelemer)

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 clinical benefit with treatment? Y N _____

[Note: Documentation must be provided.]

	[No further questions.]		
3.	Does the patient have the diagnosis of Human Immunodeficiency Virus (HIV) and is currently receiving anti-retroviral therapy?	Y N	
	[Note: Documentation must be provided.]		
	[If no, then no further questions.]		
4.	Has an adequate workup been completed to determine that the diarrhea is of non-infectious etiology?	Y N	
	[Note: Documentation must be provided.]		
	[If no, then no further questions.]		
5.	Has the patient failed three anti-diarrheals (such as loperamide, diphenoxylate/atropine, bismuth subsalicylate, or opium tincture) after a four-week trial?	Y N	
	[Note: Documentation must be provided.]		

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