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

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Qfitlia - 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 Qfitlia - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Qfitlia (fitusiran)

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 the treatment of breakthrough bleeding? Y N

[If yes, no further questions.]

2. Does the patient have any of the following: A) a history of arterial or venous thromboembolism, significant valvular Y N

	disease or atrial fibrillation, or co-existing thrombophilic disorder (e.g., Factor V Leiden mutation), B) a history of symptomatic gallbladder disease, C) a history of or are planning to undergo immune tolerance treatment, OR D) clinically significant liver disease?		
	[If yes, no further questions.]		
3.	Will the requested medication be used concurrently with Alhemo, Hemlibra, or Hympavzi?	Y N	
	[If yes, no further questions.]		
4.	Has the patient previously received treatment with a gene therapy product (e.g., Beqvez, Hemgenix, Roctavian) for the treatment of hemophilia A or B?	Y N	
	[If yes, no further questions.]		
5.	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.]		
6.	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 9.]		
7.	Is the patient experiencing benefit from therapy, evidenced by reduced frequency or severity of bleeds?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Will the patient be using the requested medication in combination with bypassing agents, factor VIII products (e.g., Advate, Adynovate, Eloctate) or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
9.	Does the patient have severe factor VIII deficiency (defined as factor VIII level of less than 1%) or severe factor IX deficiency (defined as factor IX level of less than or equal to 2%)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
10.	Will the patient be using the requested medication for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		

11. Does the patient have co-existing coagulation disorders (other than hemophilia A or B)?	Y N	
[If yes, no further questions.]		
12. Is there documentation that the patient does not have antithrombin (AT) activity less than 60% at baseline?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Is there documentation that the patient does not have alanine transaminase (ALT) and/or aspartate aminotransferase (AST) greater than 1.5 times the upper limit of normal (ULN) at baseline?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Will the prophylactic use of bypassing agents, factor VIII products, and factor IX products be discontinued no later than 7 days after the initial dose of the requested medication?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Does the provider attest that AT activity and liver enzymes will be monitored per the protocol outlined in the prescribing information?	Y N	
[If no, no further questions.]		
16. Is the patient 12 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