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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Rukobia - 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 Rukobia - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Rukobia (fostemsavir)

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. Does the patient have a human immunodeficiency virus-1 (HIV-1) infection? Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

2. Is the patient 18 years of age or older? Y N

[If no, 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)? 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 11.]	
4.	Does the patient have significant antiretroviral treatment experience with documented historical or baseline resistance, intolerability, and/or contraindications to antiretrovirals in at least three classes?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the patient had an inadequate response to current antiretroviral regimens evidenced by HIV RNA viral load greater than or equal to 400 copies per milliliter?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Does the patient have at least one responsive antiretroviral (but no more than two antiretrovirals) that can be used concurrently with the requested drug to create an effective treatment regimen?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Is or has the prescriber consulted with an infectious disease specialist, or a certified HIV provider?	Y N
	[If no, no further questions.]	
8.	Is the patient using strong cytochrome P450 3A inducers (carbamazepine, phenytoin, rifampin, enzalutamide, mitotane, St. John's wort, etc.)?	Y N
	[If yes, no further questions.]	
9.	Does the patient have a history of hypersensitivity reactions to fostemsavir or any other component of the requested drug?	Y N
	[If yes, no further questions.]	
10.	Is the patient breastfeeding?	Y N
	[No further questions.]	
11.	Is the patient using strong cytochrome P450 3A inducers (carbamazepine, phenytoin, rifampin, enzalutamide, mitotane, St. John's wort, etc.)?	Y N
	[If yes, no further questions.]	
12.	Does the patient have a history of hypersensitivity reactions to fostemsavir or any other component of the requested drug?	Y N
	[If yes, no further questions.]	
13.	Is the patient breastfeeding?	Y N
	[If yes, no further questions.]	

14. Is there documentation showing beneficial 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