

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Vemlidy - 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 Vemlidy - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Vemlidy (tenofovir alafenamide)

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 8.]

2. Does the patient have a documented diagnosis of hepatitis B virus infection with compensated liver disease?  Y  N

NOTE: Documentation must be submitted.	
[If no, no further questions.]	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
4. Is there documented negative human immunodeficiency virus (HIV)-1 infection testing prior to initiation of the requested medication?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Documentation must be submitted.	
[If no, no further questions.]	
5. Is the requested quantity less than or equal to the Food and Drug Administration (FDA) recommended dose of 1 tablet per day?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
6. Does the patient have co-infection with hepatitis B virus (HBV) and human immunodeficiency virus (HIV)-1?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
7. Does the patient have either of the following: A) End stage renal disease (estimated creatinine clearance below 15 mL per minute), B) Decompensated hepatic impairment (Child-Pugh Class B or C)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
8. Is there clinical documentation showing beneficial patient response to treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Documentation must be submitted.	

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.

<b>Prescriber (Or Authorized) Signature and Date</b>