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

4/2/2026
Prior Authorization Internal Use Only
JOHNS HOPKINS HEALTH PLANS Voranigo - 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 Voranigo - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Voranigo Tablets (vorasidenib)

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. 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 4.]		
3. Is there documentation showing that the patient has not experienced unacceptable toxicity or disease progression while on treatment?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
4. Does the patient have central nervous system (CNS) cancer?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
5. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
6. Will the requested medication be used as monotherapy adjuvant treatment of WHO grade 2 astrocytoma or WHO grade 2 oligodendroglioma?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 8.]		
7. Will the requested medication be used as monotherapy treatment of progressive or recurrent disease for ANY of the following types of CNS cancers: A) H3-mutated high-grade glioma, B) High-grade astrocytoma with piloid features (HGAP), C) WHO grade 3 Pleomorphic xanthoastrocytoma (PXA), D) WHO grade 2 or 3 oligodendroglioma and Karnofsky Performance Status (KPS) greater than or equal to 60, OR E) WHO grade 2 astrocytoma and KPS greater than or equal to 60?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
8. 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