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

JOHNS HOPKINS
HEALTH PLANS

9/9/2026	<%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS
Wayrilz - 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 Wayrilz - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Wayrilz (rilzabrutinib)

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 to normalize platelet counts?	Y N
[If yes, no further questions.]	

2. Will the requested medication be used as concomitant therapy with any thrombopoietin receptor agonists, or tyrosine kinase inhibitors used to treat thrombocytopenia?	Y N
[If yes, no further questions.]	
3. Will the requested medication be used for chronic hepatitis C-associated thrombocytopenia that does not prevent initiation or maintenance of optimal interferon-based therapy?	Y N
[If yes, no further questions.]	
4. Will the requested medication be used as initial therapy for patients' chronic immune idiopathic thrombocytopenia (ITP) without a clinical condition and whose degree of thrombocytopenia does not increase the risk for bleeding (platelet count greater than or equal to 50 x 10^9/L)?	Y N
[If yes, no further questions.]	
5. Will the requested medication be used for myelodysplastic syndrome (MDS)?	Y N
[If yes, no further questions.]	
6. Will the requested medication be used for patients who have failed to achieve platelet count greater than or equal to 50 x 10^9/L after 12 weeks of therapy?	Y N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
7. Will the requested medication be used for any other uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
8. Is the requested dose less than or equal to the maximum recommended dose?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
10. 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 13.]	
11. Has the patient's platelet count increased to greater than or equal to 50 x 10^9/L in response to the requested medication?	Y N
NOTE: Submission of medical records is required.	

[If no, no further questions.]	
12. Is the prescriber monitoring the patient's liver enzymes, complete blood count (CBC), and blood pressure routinely during therapy?	Y N
NOTE: Submission of medical records is required.	
[No further questions.]	
13. Does the patient have a documented diagnosis of chronic immune idiopathic thrombocytopenia (ITP) with platelet count less than 30 x 10^9/L?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
14. Has the patient had a trial and an insufficient response to TWO of the following therapies: A) corticosteroids, B) immunoglobulin, C) splenectomy, or D) thrombopoietin receptor agonists (Nplate or Promacta)?	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