TRICARE Prior Authorization Request Form for
levacetylleucine **(Aqneursa)**

USFHP Pharmacy Prior Authorization Form

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient weigh 15 kilograms or greater?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by a physician who specializes in the treatment of Niemann-Pick disease type C?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. What is the indication or diagnosis?	☐ Genetically confirmed diagnosis of Niemann-Pick disease type C - Proceed to question **4** ☐ Other diagnosis - **STOP Coverage not approved**	
4. Does the patient have one or more neurologic symptoms (for example, loss of motor function, difficulty swallowing, and speech and cognitive impairment)?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Will the requested medication be used concomitantly with arimoclomol (Miplyffa)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[12 February 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: