Prior Authorization Request Form for

Paltusotine HCL (Palsonify)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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.

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

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #: _____

2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an endocrinologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Acromegaly – Proceed to question **4** ☐ Other diagnosis – **STOP – Coverage cannot be approved.**	
4. Has the patient had inadequate response to surgery OR is not a candidate for surgery?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had an inadequate response to ONE injectable somatostatin analog (for example, octreotide, lanreotide, pasireotide)?	☐ Yes **Sign and date below**	☐ No Proceed to question **6**
6. Has the patient had an intolerability to ONE injectable somatostatin analog (for example, octreotide, lanreotide, pasireotide)?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**

7. Does the patient have a contraindication to ONE injectable somatostatin analog (for example, octreotide, lanreotide, pasireotide)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

3

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

Prescriber Signature _____ Date _____

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