JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Triptodur

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Central precocious puberty (CPP)
   - ❑ Gender dysphoria
   - ❑ Preservation of ovarian function
   - ❑ Recurrent menstrual related attacks in acute porphyria
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Central Precocious Puberty

3. Is the patient currently receiving the prescribed therapy for central precocious puberty?
   If Yes, no further questions. ❑ Yes ❑ No
4. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging, such as computed tomography (CT scan), magnetic resonance imaging (MRI), or ultrasound? ❑ Yes ❑ No
5. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a GnRH (gonadotropin-releasing hormone) agonist test **or** a pubertal level of a third generation LH (luteinizing hormone) assay?
   ❑ Yes ❑ No
6. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty? ❑ Yes ❑ No
7. How old was the patient **AT THE ONSET** of secondary sexual characteristics? _____ years

Section B: Gender Dysphoria

8. Is Triptodur prescribed for pubertal hormonal suppression in an adolescent patient?
   ❑ Yes ❑ No *If No, skip to #10*
9. Which Tanner Stage of puberty has the patient reached?
   ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions.*
10. Is the patient undergoing gender transition? ❑ Yes ❑ No
11. Will the patient receive Triptodur concomitantly with gender-affirming hormones? ❑ Yes ❑ No

Section C: Preservation of Ovarian Function

12. Is the patient premenopausal and undergoing chemotherapy? ❑ Yes ❑ No

Section D: Prevention of Recurrent Menstrual Related Attacks in Acute Porphyria

13. Is Triptodur prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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