Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Vemlidy - 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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vemlidy - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vemlidy (tenofovir alafenamide)

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. 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 yes, skip to question 8.]	
2. Does the patient have a documented diagnosis of hepatitis B virus infection with compensated liver disease?	Y N

	NOTE: Documentation must be submitted.	
	[If no, no further questions.]	
3.	Is the patient 18 years of age or older?	Y N
	[If no, no further questions.]	
4.	Is there documented negative human immunodeficiency virus (HIV)-1 infection testing prior to initiation of the requested medication?	Y N
	NOTE: Documentation must be submitted.	
	[If no, no further questions.]	
5.	Is the requested quantity less than or equal to the Food and Drug Administration (FDA) recommended dose of 1 tablet per day?	Y N
	[If no, no further questions.]	
6.	Does the patient have co-infection with hepatitis B virus (HBV) and human immunodeficiency virus (HIV)-1?	Y N
	[If yes, no further questions.]	
7.	Does the patient have either of the following: A) End stage renal disease (estimated creatinine clearance below 15 mL per minute), B) Decompensated hepatic impairment (Child-Pugh Class B or C)?	Y N
	[No further questions.]	
8.	Is there clinical documentation showing beneficial patient response to treatment?	Y N
	NOTE: Documentation must be submitted.	

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