maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Joenja

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? []Activated phosphoinositide 3-kinase delta syndrome (APDS) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Has documentation been provided to confirm that the requested medication is being prescribed by or in consultation with an immunologist or hematologist? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]		
5	Has the patient been established on the requested medication for at least 3 months? [Note: A patient who has received less than 3 months of therapy or who is restarting therapy with this medication is reviewed under Initial Authorization Criteria.] [If no, skip to question 8.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that the patient has had had a positive clinical response in the signs and manifestations of APDS as documented by the provider? Examples of positive clinical response in the signs and manifestations of APDS include reduction of lymph node size, spleen size, immunoglobulin replacement therapy use, infection rate, or immunoglobulin M (IgM) levels. ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Is the patient greater than or equal to 12 year(s) of age? [If no, no further questions.]	Yes	No
9	Has documentation been provided to confirm that the patient weighs GREATER THAN OR EQUAL TO 45 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient has a genetic phosphoinositide 3-kinase delta (PI3K-delta) mutation with a variant in PIK3CD and/or PIK3R1 genes? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been provided to confirm that the patient has at least one clinical finding or manifestation consistent with APDS? Examples of clinical findings or manifestations of APDS include recurrent sinopulmonary infections, recurrent herpesvirus infections, lymphadenopathy, hepatomegaly, splenomegaly, nodular lymphoid hyperplasia, autoimmunity, cytopenias, enteropathy, bronchiectasis, and organ dysfunction. ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has at least one nodal and/or extranodal lymphoproliferation measure captured on a magnetic resonance imaging (MRI) or computed tomography (CT) scan? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been provided to confirm that the patient has history of treatment for at least 3 months with corticosteroids with an inadequate response or significant side effects/toxicity? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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14	Has documentation been provided to confirm that the patient has history of treatment for at least 3 months with Sirolimus with an inadequate response or significant side effects/toxicity? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the patient a female of reproductive potential? [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the female patient of reproductive potential has a negative pregnancy test prior to initiating therapy? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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