PRIOR AUTHORIZATION REQUEST

Duvyzat

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient 6 years of age or older? [If no, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	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	Yes	No

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	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]		
4	Has the member been diagnosed with Duchenne muscular dystrophy [If no, no further questions.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Has the member been diagnosed with Duchenne muscular dystrophy (DMD)? [If no, no further questions.]	Yes	No
8	Has the provider obtained baseline platelet, triglycerides and an electrocardiogram (ECG) within 3 months prior to starting therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Does the member have a platelet count greater than 150 x 10^9/L? [If no, no further questions.]	Yes	No
10	Has member had a documented trial of corticosteroids for at least 3 months, or experienced intolerable adverse effects or contraindication to corticosteroid therapy? ACTION REQUIRED: Submit supporting documentation and check claims history. [If no, no further questions.]	Yes	No
11	Is the member ambulatory and does not require walking assistance devices? [If no, no further questions.]	Yes	No
12	Is Duvyzat (givinostat) prescribed by or in consultation with a neurologist?	Yes	No

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

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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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

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