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. 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 request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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

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	[If yes, skip to question 6.]		
4	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 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of positive clinical response in the signs and manifestations of activated phosphoinositide 3-kinase delta syndrome (APDS) include reduction of lymph node size, spleen size, immunoglobulin replacement therapy use, infection rate, or immunoglobulin M (IgM) levels.] [No further questions.]	Yes	No
6	What is the indication or diagnosis? [] Activated phosphoinositide 3-kinase delta syndrome (APDS) (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 12 year(s) of age and weighs at least 45 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	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
9	Has documentation been submitted to confirm that the patient has AT LEAST one clinical finding or manifestation consistent with activated phosphoinositide 3-kinase delta syndrome (APDS)? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of clinical findings or manifestations include recurrent sinopulmonary infections, recurrent herpesvirus infections, lymphadenopathy, hepatomegaly, splenomegaly, nodular lymphoid hyperplasia, autoimmunity, cytopenias, enteropathy, bronchiectasis, and organ dysfunction. [If no, no further questions.]	Yes	No
10	Has documentation been submitted 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.	Yes	No

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	[If no, no further questions.]		
11	Has documentation been submitted to confirm that the patient has had a treatment failure with corticosteroids for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has had a treatment failure with Sirolimus for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Is the patient a female of reproductive potential? [If no, skip to 15]	Yes	No
14	Has documentation been submitted to confirm that the female patient of reproductive potential has a negative pregnancy test prior to initiating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with an immunologist or a physician who treats patients with primary immune deficiencies? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 70 mg twice daily.]	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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