



6704 Curtis Court
Glen Burnie, MD 21060

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|------------------------------|
| For Internal Use Only |
| PA#: |
| Date Entered: |

Pharmacy Prior Authorization Form

Questions? Contact the Pharmacy Dept at:
(410) 424-4490, option 4 or
(888) 819-1043, option 4

FAX Completed form to: (410) 424-4607

Reminder: Please attach a copy of the prescription for all injectable or specialty medications

(e.g., Exjade, Norditropin, Pegasys/Ribavirin, Procrit/Aranesp, Synvisc/Hyalgan, Enbrel/Humira, Lupron, etc.)

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|-------------------------------------------|------|------------------------------------------------------------------------------------------------------------|--|
| Member Info (Please Print Legibly) | | | |
| NAME: | | Member #: | |
| DOB: | SEX: | Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse | |
| Provider Info | | | |
| NAME: | | Office Telephone: | |
| Office Contact Name: | | Office FAX: | |

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|-----------------------------|-----------------|-------------------------------|----------------------------|
| Medication Requested | | | |
| Drug Name | Strength | Dosage/Frequency (SIG) | Duration of Therapy |
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| Diagnosis / Clinical Rationale / Pertinent Labs (e.g., Hgb/Hct, HbA1c, HCV-RNA, Lipid Panel, etc.) |
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|-----------------------------------------------------------------------------------------------|--------------------------------------|--------------------------|
| Previous Formulary Trial(s) – Attach supporting progress notes and/or pharmacy profile | | |
| Drug Name/Strength/Dosage | Date(s) and Duration of Trial | Treatment Outcome |
| | | |
| | | |

I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ **Date:** _____

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|--------------------------------------------|--------------------------------------|
| For Internal Use Only | |
| <input type="checkbox"/> Approved: | Duration of Approval: _____ month(s) |
| <input type="checkbox"/> Denied: | Authorized By: |
| <input type="checkbox"/> Incomplete/Other: | Name: |
| Date Faxed to MD: | Date Decision Rendered: |