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6704 Curtis Court  
Glen Burnie, MD 21060

**Pharmacy Prior Authorization Form**

**FAX Completed form to: (410) 424-4607  
Or (410)424-4751**

**For Internal Use Only**

**PA#:**

**Date Entered:**

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

Download a copy of this form on our website at: [www.ppmco.org](http://www.ppmco.org)

**Member Info (Please Print Legibly)**

NAME:		MEDICAID #:
DOB:	SEX:	PPMCO #:

**Provider Info**

NAME:	Office Telephone:
Office Contact Name:	Office FAX:

**Medication Requested**

Drug Name	Strength	Dosage/Frequency (SIG)	Duration of Therapy

**Diagnosis / Clinical Rationale / Pertinent Labs (e.g., Hgb/Hct, HbA1c, HCV-RNA, Lipid Panel, etc.)**


**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:** \_\_\_\_\_

**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: