



6704 Curtis Court
Glen Burnie, MD 21060

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.)

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:

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:** _____

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<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: