PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/9/2026	<%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Gapabentin Extended Release Products - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Gapabentin Extended Release Products - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Gabapentin (Once-Daily) Gralise (gabapentin extended-release) Horizant (gabapentin ER)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested medication being prescribed for any indication or use that is not Food and Drug Administration (FDA)-approved?	Y N

	[If yes, then no further questions.]
2.	Is this request for continuation of therapy? Y N
	[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]
	[If no, then skip to question 4.]
3.	Is there documentation showing the patient has had clinical benefit from treatment? Y N
	[Note: Documentation must be submitted.]
	[No further questions.]
4.	Is the patient 18 years of age or older? Y N
	[If no, then no further questions.]
5.	Does the patient have a documented diagnosis of postherpetic neuralgia (PHN)? Y N
	[Note: Documentation must be submitted.]
	[If no, then skip to question 9.]
6.	Is the request for generic gabapentin once-daily? Y N
	[If yes, then no further questions.]
7.	Is the request for Brand Gralise or Horizant? Y N
	[If no, then no further questions.]
8.	Has the patient had a documented trial and inadequate response, or intolerance to generic gabapentin once-daily? Y N
	[Note: Documentation must be submitted.]
	[No further questions.]
9.	Does the patient have a documented diagnosis of moderate-to-severe primary Restless Legs Syndrome (RLS)? Y N
	[Note: Documentation must be submitted.]
	[If no, then no further questions.]
10.	Is the request for Horizant? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date