Priority Partners
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Quantity Limit Exception – Priority Partners

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 Quantity Limit Exception – Priority Partners.

Drug Name (select from list of drugs shown)
Other, Please specify

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 product being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Y N

[If no, then no further questions.]

2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? Y N

[If no, then no further questions.]

3.	Is the request for a drug with an available alternative dosage strength on the formulary that can be obtained within the quantity limits? Y N
	[If no, then skip to question 5.]
4.	Has the patient had a trial and failure with the alternative strength product within the quantity limits? Y N
	[Note: Documentation must be provided.]
	[No further questions.]
5.	Has supportive clinical rationale for the requested quantity above the Plan's quantity limit been submitted? Y N
	[Note: Documentation must be provided.]

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