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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Step Therapy 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 Step Therapy 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 use of the step-preferred drug FDA-approved, or guideline supported, for the medical condition being treated?	Y N	
[Note: Documentation must be provided.]		
[If no, then no further questions.]		
4. Has the patient experienced an inadequate treatment response to the preferred drug?	Y N	
[Note: Documentation must be provided.]		
[If yes, then no further questions.]		
5. Has the patient experienced an intolerance to the preferred drug?	Y N	
[Note: Documentation must be provided.]		
[If yes, then no further questions.]		
6. Does the patient have a contraindication that would prohibit a trial of the preferred drug?	Y N	
[Note: Documentation must be provided.]		
[If yes, then no further questions.]		
7. Is the patient a new Plan enrollee (less than 3 months since enrollment), and has a medical history of using the requested medication?	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