



**Johns Hopkins Health Plans
Compound Medication
Prior Authorization Request Form
Priority Partners**

Internal Use Only:

PA#:

Date:

*Compounds are subject to review based on ingredients and cost. Refer to the Johns Hopkins Health Plans Pharmacy Operations Coverage of Compounded Prescriptions Policy – Pharm 18 for more information.
Complete all requested information and return form with supporting progress notes to Pharmacy Review Fax: 410-424-4607 or 410-424-4751*

Member Information

Name:		MEDICAID ID#:
DOB:	SEX:	ID#:

Provider Information

Name:	Phone:
Office Contact:	Fax:

Compound Information - Document Ingredients in this compound

Compound Name (if applicable):

Ingredient #1:	Ingredient #2:
Ingredient #3:	Ingredient #4:
Ingredient #5:	Ingredient #6:

Diagnosis:

Route of administration:

Directions for use:

Proposed duration of therapy:

Rationale for use versus commercially available product:

Previous therapies including commercial products and outcomes (Include progress notes with form submission-failure to attach could result in delay):

Drug:	Outcome:
Drug:	Outcome:
Drug:	Outcome:

Additional information to support request:

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:
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	Name: