



7231 Parkway Drive, Suite 100
Hanover, MD 21076

**Fax completed form and applicable progress notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step Please complete patient and physician information (please print):

1	Patient Name:	_____	Physician Name:	_____
	Address:	_____	Address:	_____
		_____		_____
	Sponsor ID #	_____	Phone #:	_____
	Date of Birth:	_____	Secure Fax #:	_____

Step Please complete the clinical assessment:

2. Is the patient 13 years of age or older?	☐ Yes proceed to question 2	☐ No Sign and date below PA is not required for patients 12 years of age or younger
2. Please provide the reason why the patient requires Arbli oral suspension and cannot crush losartan tablets.	_____ Sign and date below	

Step I certify the above is true to the best of my knowledge. Please sign and date:

3

Prescriber Signature _____ Date _____

[12 August 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: ____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: