Prior Authorization Request Form for
Epinephrine **(Auvi-Q)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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.

Step 1 **Please complete patient and physician information** (please print):

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

Step 2 **Please complete the clinical assessment:**

1. **Auvi-Q has been identified as having cost-effective alternatives including EpiPen, EpiPen generic, and Symjepi. These agents do not require prior authorization.**	Acknowledged Proceed to question **2**
2. **Please provide a patient-specific justification as to why the patient cannot use the formulary alternatives including EpiPen, EpiPen generic, and Symjepi.**	______________________ **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________ Prescriber Signature ______________ Date

[27 May 2020]

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