Prior Authorization Request Form for

alcaftadine (Lastacaft), bepotastine (Bepreve), emedastine (Emadine)

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

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.

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:**

Question	Yes	No
1. Does the patient have ocular symptoms of allergic conjunctivitis?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Has the patient tried and failed TWO of the following formulary alternatives in the last 90 days: olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine?	☐ Yes **Sign and date below**	☐ No Proceed to question 3
3. Has the patient experienced intolerable adverse effects to at least TWO of the following formulary alternatives: olopatadine, azelastine, or epinastine?	☐ Yes **Sign and date below**	☐ No Proceed to question 4
4. What medication is being requested?	☐ Lastacaft - Proceed to question 5 ☐ Emadine - Proceed to question 5 ☐ All others – **STOP -** Coverage not approved	
5. Is the patient pregnant?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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

____________________ Prescriber Signature ____________ Date

[01 November 2017]

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