

Prior Authorization Request Form for
clobetasol propionate/emollient 0.05% foam



JOHNS HOPKINS
HEALTHCARE

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**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:

1. This agent has been identified as having cost-effective alternatives including fluocinonide 0.05% solution and clobetasol propionate 0.05% solution. These agents do not require a PA.	Proceed to question 2	
2. Has the patient tried for at least two weeks and failed, have a contraindication to, or has had an adverse reaction to clobetasol propionate 0.05% solution, lotion, gel, AND foam?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Please describe why this agent is required as opposed to available alternatives.		
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

[4 March 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: