Prior Authorization Request Form for
Compounded Medications

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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 note that only 1 form is required for each compounded product.*

Document the active ingredient(s) in this compound:

Step 3

Please complete the clinical assessment:

1. What is the diagnosis?	
2. What is the route of administration?	
3. What are the directions for use?	
4. What is the proposed duration of therapy?	

5. What is the reason that a compounded product is being prescribed rather than a commercially-available product?

6. Has the patient tried commercially available products for the diagnosis provided?	☐ Yes Proceed to 7	☐ No **SKIP** to question **8**

7. Please provide all products tried and the results of therapy:

continue to next page

Prior Authorization Request Form for
Compounded Medications

8. Is there a current national drug shortage of an otherwise commercially-available product that could be used in this patient?	☐ Yes Proceed to question 9	☐ No Proceed to question 9
9. Does the prescribed route of administration of the compound match the FDA-approved route of administration of the active ingredient(s) in the compound?	☐ Yes Proceed to question 10	☐ No Proceed to question 10
10. Is there any other information you would like to provide to support this request? If "Yes", please document below:	☐ Yes Proceed to 11	☐ No Proceed to 11

11. Please submit evidence with this form to support that: **(1)** each ingredient is lawfully marketed in the U.S. and is proven safe and effective (that is, [i] approved for commercial marketing by the FDA, [ii] proven safe and effective under TRICARE standards, or [iii] meets the requirements for being widely recognized in the U.S. as being safe and effective), **(2)** the compound is clinically appropriate for the patient, and, **(3)** an FDA-approved commercially-available product is not appropriate because the patient requires a unique dosage form or concentration, or for other clinical reason.

Step 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[18 January 2017]

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