Prior Authorization Request Form for
desoximetasone 0.05% gel

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:**

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 fluocinonide 0.05% solution AND gel?**	☐ Yes Proceed to question **3**	☐ 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	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: