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 explain why the patient cannot be treated with the formulary medications. Circle a reason code if it applies. You MUST supply a specific written clinical explanation as to why EACH formulary medication would be unacceptable.**

Formulary Medication	Reason	Clinical Explanation
Levothyroxine sodium tablets	**1**	
Levothyroxine sodium liquid filled capsules	**1**	
Levothyroxine sodium oral solution (Tirosint-Sol)	**1**	

Clinical exception can be considered for:

1. No alternative formulary agent (for example: patient is not able to swallow capsule or sprinkle capsule on food or chew a tablet)

Step 3 **I certify that the above is correct to the best of my knowledge** (Please sign and date):

_____ _____
Prescriber Signature Date

[17 May 2023]

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