



JOHNS HOPKINS
HEALTH PLANS

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.

Note: Prior authorization criteria applies for patients who are older than 12 years.

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. Which medication is requested?	<input type="checkbox"/> Pulmicort Flexhaler (budesonide) – Proceed to question 2 <input type="checkbox"/> All others – Proceed to question 3	
2. (Pulmicort Flexhaler/ budesonide request) Is the patient a female who is pregnant?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient tried fluticasone propionate and experienced an inadequate response or an intolerable adverse effect?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have a contraindication to fluticasone propionate?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5
5. Has the patient previously responded to the requested drug and changing to fluticasone propionate would incur an unacceptable risk?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

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

_____ Prescriber Signature _____ Date

[26 June 2024]

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: