

Prior Authorization Request Form for
ivermectin (**Stromectol**)



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.

Prior authorization expires in 6 months. Note: PA would only apply to outpatient use, and would not impact any investigational protocols.

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. Is ivermectin being used for an FDA-approved indication including intestinal strongyloidiasis or onchocerciasis (river blindness)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to Question 2
2. Is ivermectin being used to treat or prevent COVID-19?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to Question 3
3. Is the requested medication prescribed for ascariasis (roundworm), demodicosis, gnathostomiasis, cutaneous larva migrans (dog and cat hookworm), pediculosis (lice), Mansonella ozzardi infection, Mansonella streptocerca infection, scabies, trichuriasis (whipworm), or Wucheria bancrofti infection?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to Question 4
4. Is ivermectin prescribed by or in consultation with an infectious disease provider?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

Prescriber Signature

Date

[20 September 2021]

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: