Prior Authorization Request Form for Mefloquine (Lariam)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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. Is the patient requiring mefloquine (Lariam) for malaria chemoprophylaxis (that is, not for treatment of acute malaria infections)?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Does the patient have a contraindication or intolerance to both atovaquone-proguanil (Malarone) and doxycycline (for example, pregnancy)?	☐ **Yes** **Proceed to question 3**	☐ **No** **STOP** **Coverage not approved**
3. Does the patient have a major psychiatric disorder, including, but not limited to, active or recent history of depression, generalized anxiety disorder, psychosis or schizophrenia, post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Proceed to question 4**
4. Does the patient have a history of seizures or vestibular disorders?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Proceed to question 5**
5. Does the patient have a cardiac conduction abnormality?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Proceed to question 6**
6. Please document the total treatment duration in months and proceed to question 7 _____		
7. Is the above information documented in the patient's medical record and the patient has been educated on mefloquine adverse effects and dosing?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

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

_____ _____

Prescriber Signature Date

[27 March 2017]

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