Prior Authorization Request Form for
olopatadine **(Pataday)**

JOHNS HOPKINS MEDICINE
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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. Does the patient have ocular symptoms of allergic conjunctivitis?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Has the patient tried and failed TWO of the following formulary alternatives in the last 90 days: olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine?	☐ Yes **Sign and date below**	☐ No Proceed to question 3
3. Has the patient experienced intolerable adverse effects to at least TWO of the following formulary alternatives: olopatadine, azelastine, or epinastine?	☐ Yes **Sign and date below**	☐ 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

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