Prior Authorization Request Form for
tacrolimus oral suspension (**Prograf**)

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 less than 12 years of age?	☐ Yes **STOP** **Prior Authorization Not Required**	☐ No Proceed to question **2**
2. Is the requested medication being prescribed by or in consultation with a transplant specialist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have severe dysphagia (for example, severe esophagitis, mucositis) or is completely unable to swallow (for example, has G-tube)?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Is the patient less than 18 years old and has difficulty swallowing tablets/capsules?	☐ 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

[14 August 2019]

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