Prior Authorization Request Form for Asfotase alpha injection **(Strensiq)**

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. Does the patient have the FDA-approved indication of perinatal/infantile and juvenile-onset hypophosphatasia?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Has the diagnosis been supported by confirmatory testing?	☐ Yes Sign and date below	☐ 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

[4 May 2016]

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