JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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 requested medication prescribed by an optometrist or ophthalmologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC)?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient tried and failed an adequate course of at least one mast cell stabilizer/antihistamine (for example, olopatadine, azelastine, epinastine, lodoxamide, cromolyn)?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed or have a contraindication to an adequate course of cyclosporine 0.05% ophthalmic emulsion (Restasis)?	☐ 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

[9 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: