Prior Authorization Request Form for
pancrelipase **(Zenpep)**

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:

Question	Yes	No
1. Is the patient less than or equal to 2 years of age?	☐ Yes **Proceed to question 2**	☐ No **Proceed to question 3**
2. Has the patient had a sufficient trial of Creon and treatment was unsuccessful?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Has the patient failed an adequate trial of Creon, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** ________________	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient failed an adequate trial of Pancreaze, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** ________________	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient failed an adequate trial of Pertzye, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** ________________	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
pancrelipase **(Zenpep)**

Question	Yes	No
6. **Has the patient failed an adequate trial of Viokace, defined as at least 2 dose adjustments done over a period of at least 4 week?** ***Please provide the trial dates ________________***	☐ Yes **Sign and date below**	☐ No **Proceed to question 7**
7. **Is the patient between 2 and 19 years of age?**	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. **Does the patient require a dosage strength that is not available with Viokace?**	☐ 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

[31 July 2019]

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