



Prior Authorization
JOHNS HOPKINS HEALTHCARE (MEDICAID) Non-Formulary Exception – Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Non -Formulary Exception – Priority Partners MCO.

Drug Name (select from list of drugs shown) Other, Please specify
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Is the requested product being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	

3. Is the request for a combination product for which individual components are available at similar doses on formulary?	Y N
[If no, then skip to question 5.]	
4. Has the patient had a trial and failure of the separate individual components due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Y N
[Note: Documentation must be provided.]	
[If no, then no further questions.]	
5. Is the request for a brand name product that has a generic available on formulary?	Y N
[If no, then skip to question 7.]	
6. Has the patient had a trial and failure of the generic agent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Y N
[Note: Documentation must be provided.]	
[If no, then no further questions.]	
7. Is the request for a drug with an available alternative dosage form for the same active ingredient on formulary?	Y N
[If no, then skip to question 9.]	
8. Is there a clinical reason why the patient is unable to take an applicable alternative formulary dosage form based on the patient's condition (e.g. age, indication)?	Y N
[Note: Documentation must be provided.]	
[If no, then no further questions.]	
9. Is the patient unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance or an expected adverse reaction or contraindication? (Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative.)	Y N
[Note: Documentation must be provided.]	
[If yes, then no further questions.]	
10. Is the patient a new Plan enrollee (less than 3 months since enrollment), and has a medical history of using the requested medication?	Y N
[Note: Documentation must be provided.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is

available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date