



Prior Authorization
JOHNS HOPKINS HEALTHCARE (MEDICAID) Quantity Limit 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 Quantity Limit Exception – Priority Partners MCO.

Drug Name (select from list of drugs shown) Other, Please specify
--

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: _____
-------------------------	------------------------

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 drug with an available alternative dosage strength on the formulary that can be obtained within the quantity limits?	Y N
[If no, then skip to question 5.]	
4. Has the patient had a trial and failure with the alternative strength product within the quantity limits?	Y N
[Note: Documentation must be provided.]	
[No further questions.]	
5. Has supportive clinical rationale for the requested quantity above the Plan's quantity limit been submitted?	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