Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Step Therapy 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 Step Therapy 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)? Y 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? Y N

[If no, then no further questions.]

3.	Is the use of the step-preferred drug FDA-approved, or guideline supported, for the medical condition being treated?	Y N
	[Note: Documentation must be provided.]	
	[If no, then no further questions.]	
4.	Has the patient experienced an inadequate treatment response to the preferred drug?	Y N
	[Note: Documentation must be provided.]	
	[If yes, then no further questions.]	
5.	Has the patient experienced an intolerance to the preferred drug?	Y N
	[Note: Documentation must be provided.]	
	[If yes, then no further questions.]	
6.	Does the patient have a contraindication that would prohibit a trial of the preferred drug?	Y N
	[Note: Documentation must be provided.]	
	[If yes, then no further questions.]	
7.	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