



**Johns Hopkins HealthCare
Compound Medication
Prior Authorization Request Form
For USFHP ONLY**

Internal Use Only:

PA#:

Date:

Compounds are subject to review based on ingredients and cost. Refer to the Johns Hopkins Healthcare Pharmacy Operations Coverage of Compounded Prescriptions Policy – Pharm 18 for more information.

Complete all requested information and return form with supporting progress notes to Pharmacy Review Fax: 410-424-4037

Form can be downloaded from our website:

https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/usfhp/forms.html

Member Information

Name:

Health Plan: USFHP

DOB:

SEX:

ID#:

Provider Information

Name:

Phone:

Office Contact:

Fax:

Compound Information - Document Ingredients in this compound

Compound Name (if applicable):

Ingredient #1:

Ingredient #2:

Ingredient #3:

Ingredient #4:

Ingredient #5:

Ingredient #6:

Diagnosis:

Route of administration:

Directions for use:

Proposed duration of therapy:

Rationale for use versus commercially available product:

Previous therapies including commercial products and outcomes (Include progress notes with form submission-failure to attach may result in delay):

Drug:

Outcome:

Drug:

Outcome:

Drug:

Outcome:

Additional information to support request:

I certify that the clinical information provided on this form is complete and accurate:

Provider Signature: _____ Date: _____

For Internal Use Only

Approved:

Duration of Approval:

Denied:

Authorized By:

Incomplete/Other:

Name: