



6704 Curtis Court
Glen Burnie, MD 21060

For Internal Use Only
PA#:
Date Entered:

USFHP Pharmacy Prior Authorization Form

Questions?
Contact the Pharmacy Dept at:
(888) 819-1043, option 4

**FAX Completed Form AND APPLICABLE
PROGRESS NOTES to: (410) 424-4037**

Member Info (Please Print Legibly)			
NAME:		Member #:	
DOB:	SEX:	Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	
Provider Info			
NAME:		Office Telephone:	
Office Contact Name:		Office FAX:	

Medication Requested			
Drug Name	Strength	Dosage/Frequency (SIG)	Duration of Therapy

Diagnosis / Clinical Rationale / Pertinent Labs
Attach supporting progress notes - failure to attach may result in delay

Previous Formulary Trial(s)		
Attach supporting progress notes - failure to attach may result in delay		
Drug Name/Strength/Dosage	Date(s) and Duration of Trial	Treatment Outcome

Attestations required for prior authorization review:

- Supporting progress notes/clinical documentation are attached - *failure to attach may result in delay.*
- I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ **Date:** _____

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<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: