Prior Authorization Request Form for
duloxetine delayed-release capsules (**Drizalma Sprinkle**)

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100 Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider
Drug Name:
Duration of Therapy:

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

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

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	__________	Physician Name:	__________
Address:	__________	Address:	__________
	__________		__________
Sponsor ID #	__________	Phone #:	__________
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. **Please explain why the patient requires duloxetine sprinkle capsules and cannot take alternatives.**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

____________________ __________
Prescriber Signature Date

[19 February 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: