

Prior Authorization Request Form for  
rosuvastatin sprinkle capsules (**Ezallor Sprinkle**)



**JOHNS HOPKINS**  
M E D I C I N E

JOHNS HOPKINS  
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

**USFHP Pharmacy Prior Authorization Form**

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**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:

**Please explain why the patient requires rosuvastatin sprinkle capsules (Ezallor Sprinkle) and cannot take simvastatin, atorvastatin, OR rosuvastatin tablets.**

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

_____	_____
Prescriber Signature	Date

[13 November 2019]

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