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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Non-Formulary Exception – Priority Partners

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 Health Plans 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 Non-Formulary Exception – Priority Partners.

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 request for a combination product for which individual components are available at similar doses on formulary? Y N
	[If no, then skip to question 5.]
4.	Has the patient had a trial and failure of the separate individual components due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? Y N
	[Note: Documentation must be provided.]
	[If no, then no further questions.]
5.	Is the request for a brand name product that has a generic available on formulary? Y N
	[If no, then skip to question 7.]
6.	Has the patient had a trial and failure of the generic agent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? Y N
	[Note: Documentation must be provided.]
	[If no, then no further questions.]
7.	Is the request for a drug with an available alternative dosage form for the same active ingredient on formulary? Y N
	[If no, then skip to question 9.]
8.	Is there a clinical reason why the patient is unable to take an applicable alternative formulary dosage form based on the patient's condition (e.g. age, indication)? Y N
	[Note: Documentation must be provided.]
	[If no, then no further questions.]
9.	Is the patient unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance or an expected adverse reaction or contraindication? (Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative.) Y N
	[Note: Documentation must be provided.]
	[If yes, then no further questions.]
10.	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