JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

For Internal Use Only
PA#:
Date Entered:

Questions?
Contact the Pharmacy Dept at:
(410) 424-4490, option 4 or
(888) 819-1043, option 4

Priority Partners Pharmacy Prior Authorization Form

Fax completed form and applicable progress notes to: (410) 424-4607 or (410) 424-4751

Member Info (Please Print Legibly)		
Name:		MEDICAID #:
DOB:	Sex:	PPMCO #:
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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☐ Approved:	Duration of Approval: _____ month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: