Johns Hopkins Health Plans Medical Injectable Prior Authorization Request Form *For USFHP*

For Internal Use Only
PA#:
Date Entered:

1. **Download a copy of this form on our website at: HopkinsHealthPlans.org > For Providers > Our Health Plans > USFHP > Forms.**
2. **Complete all requested information. *Incomplete form and lack of supporting progress notes may result in delay.***
3. **Fax completed form and supporting notes to Pharmacy Review: 410-424-2801. For questions, call: 1-888-819-1043, option 4.**

Member Info (Please Print Legibly)			
NAME:		HEIGHT:	WEIGHT:
DOB:	SEX: ☐ Male ☐ Female	MEMBER ID:	RECEPIENT ID:
Prescriber Information			
NAME:		PROVIDER NPI:	
OFFICE CONTACT:		TAX ID:	
PHONE:		FAX:	
Billing Info [Outpatient | Office | Infusion Center]: ☐ ***Check if same as Prescriber Information***			
NAME:		ADDRESS:	
CONTACT:		PHONE:	FAX:
NPI:		TAX ID:	

Place of Service:
☐ **Freestanding Outpatient Infusion Center (POS Code 24)** ☐ **Office (POS 11)** ☐ **Patient's Home (POS 12)**
☐ **Outpatient (POS 19, 22)*** **Maryland hospital or regulated setting*

Drug Code (Medication requested):			
Drug Name	**HCPCS Billing Code**	**Dosage/Frequency (SIG)**	**Tx Duration (Months)**
Dates of Service:		***Number of Administrations Per Month:***	
ICD-10 Diagnosis Code(s):		***Drug Administration CPT Code(s):***	
Previous Therapy and Outcomes **Attach supporting progress notes–failure to attach may result in delay*			
Provider/Facility will supply (buy and bill) medication:		☐ **Yes** ☐ **No**	

Attestations required for prior authorization review:

☐ Supporting progress notes/clinical documentation are attached.

☐ I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ **Date:** _____

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☐ Approved ☐ Denied ☐ Incomplete/Other		Duration of Approval: month(s)
Decision By:	Date Decision Rendered:	Dosage Approved: