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

For Internal Use Only
PA#:
Date Entered:

USFHP Pharmacy Prior Authorization Form

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

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

Member Info (Please Print Legibly)		
NAME:		Member #:
DOB:	Sex:	Relationship: ☐ Self ☐ Child ☐ Spouse
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:** _____

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