Pharmacy Prior Authorization Request Form

FOR USFHP ONLY

Non-Formulary Copay Reduction Request Form

The purpose of this form is to provide information that will be used to determine if the use of a non-formulary (Tier 3) medication is medically necessary. If a non-formulary medication is determined to be medically necessary, it may be obtained at the formulary brand (Tier 2) cost share.

Fax completed form and applicable progress notes to 410-424-4037.

Please contact the Pharmacy department at 888-819-1043 option 4 with any questions.

Patient Information (please print)		**Provider Information (please print)**
Patient Name:		Provider Name:
Address:		Address:
Sponsor ID #:	Date of Birth:	Phone #:
		Secure Fax#:

Medication Information

Medication Name:	Strength, Dosage Form and Directions for use:

Patients Diagnosis with ICD-10 Code(s):

Please explain why the patient cannot be treated with formulary medications, and specify ALL medications tried, intolerances, and contraindications:

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

☐ 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: