JOHNS HOPKINS MEDICINE
EMPLOYER HEALTH PROGRAMS

www.ehp.org
6704 Curtis Court
Glen Burnie, MD 21060

For Internal Use Only
PA#:
Date Entered:

Pharmacy Prior Authorization Form

FAX Completed Form AND APPLICABLE PROGRESS NOTES to: (410) 424-4607
Or (410)424-4751

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

Download a copy of this form on our website at: **www.ehp.org**

Member Info (Please Print Legibly)				
NAME:			Member #:	
DOB:	SEX:		Relationship: ☐ Self ☐ Child ☐ Spouse	
Provider Info				
NAME:			Provider NPI:	
Office Contact Name:		Office Telephone:		Office FAX:

Medication Requested			
Drug Name	**Strength**	**Dosage/Frequency (SIG)**	**Duration of Therapy**

Diagnosis / Clinical Rationale / Pertinent Labs – **Attach supporting progress notes**

Previous Formulary Trial(s) – **Attach supporting progress notes**		
Drug Name/Strength/Dosage	**Date(s) and Duration of Trial**	**Treatment Outcome**

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: