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6704 Curtis Court
Glen Burnie, MD 21060

Pharmacy Prior Authorization Form

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

For Internal Use Only
PA#:
Date Entered:

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.ppmco.org

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**

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

<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: