Johns Hopkins Health Plans
Compound Medication
Prior Authorization Request Form
Priority Partners

Internal Use Only:
PA#:
Date:

Compounds are subject to review based on ingredients and cost. Refer to the Johns Hopkins Health Plans Pharmacy Operations Coverage of Compounded Prescriptions Policy – Pharm 18 for more information.
Complete all requested information and return form with supporting progress notes to Pharmacy Review Fax: 410-424-4607 or 410-424-4751

Member Information		
Name:	MEDICAID ID#:	
DOB:	SEX:	ID#:
Provider Information		
Name:	Phone:	
Office Contact:	Fax:	
Compound Information - Document Ingredients in this compound		
Compound Name (if applicable):		
Ingredient #1:	Ingredient #2:	
Ingredient #3:	Ingredient #4:	
Ingredient #5:	Ingredient #6:	
Diagnosis:		
Route of administration:		
Directions for use:		
Proposed duration of therapy:		
Rationale for use versus commercially available product:		
Previous therapies including commercial products and outcomes (*Include progress notes with form submission-failure to attach could result in delay*):		
Drug:	Outcome:	
Drug:	Outcome:	
Drug:	Outcome:	
Additional information to support request:		
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:	
☐ Denied:	Authorized By:	
☐ Incomplete/Other:	Name:	