



7231 Parkway Drive, Suite 100  
Hanover, MD 21076

**For Internal Use Only****PA#:****Date Entered:****Priority Partners 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

**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\*\*** - 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**

<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: