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PA#:
Date Entered:

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

Pharmacy Prior Authorization Form

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

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

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:** _____

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☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: