

**PREAUTHORIZATION FOR PRESCRIPTIONS OVER \$2,500.00**

**Initiation of Therapy  
Maryland Pharmacy Program**

Incomplete forms will be returned-

410-767-1455 or 1-800-492-5231 Option 3

Fax form to: 410-333-5398

**Section I. Patient Information**

Patient location: \_\_\_ Home \_\_\_ Hospital \_\_\_ Clinic \_\_\_ Office Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Patient Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

MA ID#: \_\_\_\_\_ **A copy of Patient Medical History should accompany this request.**

**Section II- Drug is used for an FDA-approved indication**

Name of Drug/Strength: \_\_\_\_\_ Dosage frequency: \_\_\_\_\_

Is this dosage within the FDA-recommended range?  Yes  No – If no, explain why: \_\_\_\_\_

Diagnosis justifying use of this drug in this patient for the FDA-approved indication (Do not use ICD-9): \_\_\_\_\_

For certain highly specific conditions, provide results of pertinent lab tests or values confirming above diagnosis: \_\_\_\_\_

Provide justification for selecting this high-cost drug over other less expensive yet equally effective therapeutic alternatives: \_\_\_\_\_

**Section III- Drug is used off-label**

Drug Name/Strength: \_\_\_\_\_ Dosage frequency: \_\_\_\_\_

Is this dosage within the FDA-recommended dosage range for the approved use?  Yes  No- If no, explain why: \_\_\_\_\_

List off-label use(s) for the prescribed drug: \_\_\_\_\_

Decision for the off-label use for this drug based on what source of information? \_\_\_\_\_

List references that support such use for the diagnosis as documented above: \_\_\_\_\_

Any additional information why this drug is medically necessary and appropriate: \_\_\_\_\_

List any agents tried for this condition in this patient: (Use additional blank paper if more space is needed)

Drug: \_\_\_\_\_ Period used: Fr \_\_\_\_\_ to \_\_\_\_\_. Did drug fail?  Yes  No \_\_\_\_\_

Drug: \_\_\_\_\_ Period used: Fr: \_\_\_\_\_ to \_\_\_\_\_. Did drug fail?  Yes  No \_\_\_\_\_

List any other alternative FDA-approved drug(s) that could be considered for this patient but not used:

Drug: \_\_\_\_\_ Reason for not choosing this drug: \_\_\_\_\_

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**Note:** Off-label use or use of this drug at dosages other than recommended by FDA may be approved if medically necessary, safe, appropriate, and documented in one of the three official compendia (the AHFS Drug Information, the Micromedex Drugdex, and the US Pharmacopeia).

Is drug used as part of a clinical study or trial?  No  Yes- If yes, specify sponsoring organization/drug manufacturer

Specify purpose of study: \_\_\_\_\_

I certify that the information provided is accurate. Supporting documentation kept in the patient's medical record is available for State audits.

\_\_\_\_\_, M.D. Prescriber's Name: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

(Prescriber's signature). Tel# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Fax# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Specialty : \_\_\_\_\_

Address: \_\_\_\_\_

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**PREAUTHORIZATION FOR PRESCRIPTIONS OVER \$2500**

**Continuation of Therapy  
Maryland Pharmacy Program**

**Incomplete forms will be returned-** 410-767-1455 or 1-800-492-5231 Option 3 Fax form to: 410-333-5398

**Section I- Patient Information**

Patient location: \_\_\_ Home; \_\_\_ Hospital \_\_\_ Clinic \_\_\_ Office Date of birth: \_\_\_/\_\_\_/\_\_\_  
Patient Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_  
MA ID#: \_\_\_\_\_

**Section II- Rx Information**

Drug/Strength: \_\_\_\_\_ Dosage frequency: \_\_\_\_\_  
Date of Initial therapy: \_\_\_/\_\_\_/\_\_\_

**Section III- Continuation of Therapy**

Provide any applicable monitoring parameters and lab tests results to support safe continuation of therapy for this drug in this patient:

Drug level: \_\_\_\_\_ Date measured: \_\_\_\_\_

Lab tests: Specify type (i.e. liver function test, blood test, etc.):

_____	Test Date: _____	<input type="checkbox"/> Results normal	<input type="checkbox"/> Results abnormal
_____	Test Date: _____	<input type="checkbox"/> Results normal	<input type="checkbox"/> Results abnormal
_____	Test Date: _____	<input type="checkbox"/> Results normal	<input type="checkbox"/> Results abnormal
_____	Test Date: _____	<input type="checkbox"/> Results normal	<input type="checkbox"/> Results abnormal
_____	Test Date: _____	<input type="checkbox"/> Results normal	<input type="checkbox"/> Results abnormal

Patient's clinical response to the drug has been  positive  negative

Is medication approved for long-term use?  Yes  No

If drug is not indicated for long-term use, does the medical literature or official compendia support safe chronic use of the drug?  Yes  No

Action taken:

- Continue same therapy for: \_\_\_ months
- Discontinue therapy due to: \_\_\_ side-effects/adverse events  
 \_\_\_ therapeutic failure or lack of response  
 \_\_\_ Other reasons: \_\_\_\_\_
- Replace drug with \_\_\_\_\_  Add following agent to existing therapy \_\_\_\_\_

Based on an evaluation of patient's clinical conditions, lab test results and clinical data, is continuation of this high-cost therapy justified in terms of long-term safety and efficacy in this patient?  Yes  No

Comment on the drug's efficacy, adverse effects, or any compliance issues: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have evaluated and monitored patient's lab test results & clinical data to ensure safe use of this drug in this patient. Supporting documentation kept in the patient's medical records is available for State audits.

\_\_\_\_\_, M.D. Prescriber's name: \_\_\_\_\_  
 (Prescriber's signature) Date: \_\_\_/\_\_\_/\_\_\_  
 Tel# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Fax# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
 License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Specialty : \_\_\_\_\_  
 Address: \_\_\_\_\_

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