Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

CGRP Antagonists - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have at least 4 migraine days per month?

☐ Yes ☐ No

Q2. Does the patient have a confirmed intolerance or inadequate response to a trial with at least one preventive medication from two of the following classes: beta blockers, antidepressants, anticonvulsants)?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of episodic cluster headaches?

☐ Yes ☐ No

Q4. Does the patient have a history of inadequate response, intolerance or contraindication to at least one other preventative medication recommended by current consensus guidelines for episodic cluster headache?

☐ Yes ☐ No

Q5. Additional Information:

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Patient Name:	**Prescriber Name:**

Q6. Requested Duration:

☐ 12 months ☐ Other:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request