Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Cresemba

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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: □ Exchange - PA	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 the 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. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Does the patient have any contraindications to the prescribed drug?

☐ Yes ☐ No

Q3. Is the patient currently receiving Cresemba?

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q5. Is the drug being prescribed by or in consultation with an infectious disease specialist?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient have a diagnosis of ONE of the following: A) Treatment of invasive aspergillosis and therapeutic failure of or a contraindication or an intolerance to voriconazole OR B) Treatment of invasive mucormycosis?

☐ Yes ☐ No

Q7. Is the drug is being used for a medically accepted indication? Please provide documentation.

☐ Yes ☐ No

Q8. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to first-line therapy(ies) if applicable according to consensus treatment guidelines?

☐ Yes ☐ No

Q9. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request