2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Corticotropin Gel - 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 a documented diagnosis of an FDA-approved indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q2. Is there evidence of scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin, a congenital infection suspected in an infant, or administration of a live or live attenuated vaccine in a patient receiving immunosuppressive doses of corticotropin gel?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of infantile spasms?

☐ Yes ☐ No

Q4. Is the patient less than 2 years of age?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of multiple sclerosis?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. For other FDA-approved indications not otherwise excluded from Part D, is the patient older than 2 years of age?

☐ Yes ☐ No

Q8. Is the medication going to be furnished by the prescriber/office, administered in the prescriber's office or ambulatory setting, be billed by the prescriber/office, and covered under Medicare Part B?

☐ Yes ☐ No

Q9. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

☐ Yes ☐ No

Q10. Does the patient have a diagnosis of infantile spasms?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 12 months ☐ 1 month

Q12. Additional Information:

_______________________________ _______________________

Prescriber Signature Date

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