



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Xermelo

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax: Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, 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.

Form with fields: 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 18 years of age or older?

Yes No

Q2. Is this a renewal request or continuation of therapy request? If Yes, go to 6.

Yes No

Q3. Is documentation of the patient's diagnosis included showing a diagnosis of carcinoid syndrome diarrhea inadequately controlled (at least 4 bowel movements per day) despite a 3-month trial of somatostatin analog therapy?

Yes No

Q4. Are there records confirming concurrent SSA therapy?

Yes No

Q5. Is the medication being prescribed by or in consultation with a specialist (such as oncologist, endocrinologist, or gastroenterologist)?



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is documentation attached showing a positive clinical response to therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Additional Information:	
Q8. Duration:	
<input type="checkbox"/> 12 months	<input type="checkbox"/> Other

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date  
2024 Prior Authorization Request