

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Plegridy 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):		
	TED REVIEW: By checking this box and signing below, e's ability to regain maximum function.	I certify that the standard review timefr	rame may seriously jeopardize the life or health of	
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. Request T	ype:			
☐ Initial - Go to 2		☐ Continuation - Go	o to 5	
Q2. Is the requested medication prescribed by or in consultation with a neurologist?				
☐ Yes		□ No		
Q3. Is the requested medication being used concomitantly with other disease modifying multiple sclerosis agents (Note: Ampyra and Nuedexta are not disease modifying)?				
☐ Yes		□No		
Q4. Does the patient have one of the following diagnoses: A) Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse); B) clinically isolated syndrome?				
☐ Yes		□ No		
Q5. For continuation, is the patient experiencing disease stability or improvement while receiving the medication?				

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Patient Name:	Prescriber Name:		
□Yes	□ No		
Q6. Additional Information:			
Prescriber Signature	 Date		

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