Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Signifor

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 this a request for reauthorization?

☐ Yes ☐ No

Q2. Is there a confirmed decrease in urinary free cortisol levels from baseline?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a documented diagnosis of Cushing's Disease?

☐ Yes ☐ No

Q5. Does the patient meet both of the following: a. Pretreatment cortisol level confirmed by Urinary free cortisol (UFC), Late-night salivary cortisol (LNSC), 1 mg overnight dexamethasone suppression test (DST), OR Longer, low dose DST (2 mg per day for 48 hours); b. Patient is not a candidate for pituitary surgery OR pituitary surgery has not been curative?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Additional Information:	

Prescriber Signature _____ Date _____

v2025