Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Strensiq

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 renewal request? If yes, go to Q8. If no, go to Q2.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

☐ Yes ☐ No

Q3. Did the onset of disease occur prior to age of 18 years?

☐ Yes ☐ No

Q4. Are applicable labs and/or tests provided supporting the diagnosis? Labs/tests include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

☐ Yes ☐ No

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Q5. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?

☐ Yes ☐ No

Q6. Has the member been appropriately evaluated and confirmation the member does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?

☐ Yes ☐ No

Q7. Is the requested dose within the FDA labeled dosing guidelines (patient's weight must be provided)?

☐ Yes ☐ No

Q8. Has documentation of clinical benefit been provided, as shown by improvement in any of the following: radiographic findings, respiratory assessments, pulmonary function testing, growth parameters, mobility, pain assessments?

☐ Yes ☐ No

Q9. Has documentation of ophthalmic and renal monitoring (concern for ophthalmic or renal ectopic calcifications) been provided?

☐ Yes ☐ No

Q10. Is the requested dose within the FDA labeled dosing guidelines (patient's weight must be provided)?

☐ Yes ☐ No

Q11. Additional Information:

☐ Yes ☐ No

Prescriber Signature _____ Date _____

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