PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Brinsupri

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 the request for a reauthorization of Brinsupri? If YES, go to 2. If NO, go to 5.

☐ Yes ☐ No

Q2. The member has a diagnosis of non-cystic fibrosis bronchiectasis (NCFB).

☐ Yes ☐ No

Q3. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist.

☐ Yes ☐ No

Q4. The patient has experienced a positive response to therapy (e.g., reduction in pulmonary exacerbations from baseline).

☐ Yes ☐ No

Q5. The member is 12 years of age or older.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Brinsupri

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:**

☐ Yes ☐ No

Q6. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q7. The member has a documented diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest computed tomography (CT) scan. Attach documentation.

☐ Yes ☐ No

Q8. The member has a documented clinical history consistent with bronchiectasis (chronic cough, chronic sputum production, and/or recurrent RTIs). Attach documentation.

☐ Yes ☐ No

Q9. The member has documentation of one of the following (attach documentation):

☐ a. For 18 years of age and older, the member has experienced at least two (2) exacerbations in the previous 12 months that led to antibiotic treatment

☐ b. For 12 years of age to less than 18 years of age, the member has had at least one (1) pulmonary exacerbation in the previous 12 months that led to antibiotic treatment.

Q10. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist.

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Brinsupri

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:**

v2026

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document