

**2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM**



Drizalma Sprinkle - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour 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 administration via nasogastric tube required or is there documentation that the patient has an inability to swallow an intact capsule?**

Yes

No

**Q2. Does the patient have a documented diagnosis of MDD with inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g. fluoxetine liquid, citalopram solution, escitalopram solution, sertraline concentrate)?**

Yes

No

**Q3. Does the patient have a documented diagnosis of GAD with inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g. escitalopram solution, paroxetine suspension)?**

Yes

No

**Q4. Does the patient have a documented diagnosis of DPNP or FM with inadequate response, intolerance, or contraindication to gabapentin solution?**

Yes

No

**Q5. Does the patient have a documented diagnosis of chronic musculoskeletal pain?**

Yes

No

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Patient Name:	Prescriber Name:
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is the patient 7 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Additional Information:	
Q9. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other	

Prescriber Signature

Date

2024 Medicare Prior Authorization Request