

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Rezurock - 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.

Patient Name:	Prescriber Name:	
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:	Specialty/facility name (if applicable):	

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.**

<p>Q1. Is Rezurock being used for an FDA-approved Indication not otherwise excluded from Part D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient 12 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the drug prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient female of childbearing age or male with female partners of reproductive potential?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Has confirmation been provided that effective contraception will be used during treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has confirmation of a trial and failure of at least 2 conventional systemic treatments for chronic graft-versus-host disease been provided?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Patient Name:	Prescriber Name:
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Q7. Duration:

12 months

Other

Q8. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request