Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Opipza Oral Film - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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.

Q1. Is there documentation showing inability to or difficulty with swallowing solid dosage forms?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of Tourette's disorder or irritability associated with autistic disorder? If YES, go to question 5.

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of schizophrenia? If YES, go to question 6.

☐ Yes ☐ No

Q4. Does the patient have a diagnosis major depressive disorder (MDD) requiring adjunctive treatment? If YES, go to question 7.

☐ Yes ☐ No

Q5. Is the patient 6 years of age or older? If YES, go to question 8.

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is the patient 13 years of age or older? If YES, go to 9.

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older? If YES, go to 9.

☐ Yes ☐ No

Q8. Is there documentation of inadequate response, intolerance or contraindication to generic aripiprazole?

☐ Yes ☐ No

Q9. Is there documentation of inadequate response, intolerance or contraindication to generic aripiprazole and documentation of inadequate response, intolerance or contraindication to at least one other generic atypical antipsychotic indicated for the patient's condition?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months ☐ Other:

Q11. Additional information:

_____ _____

Prescriber Signature Date

v2025