Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Arikayce - 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. Does the patient have a documented diagnosis of Mycobacterium avium complex (MAC) lung disease?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is there confirmation that the medication is being used as part of a combination antibacterial drug regimen?

☐ Yes ☐ No

Q4. Is there confirmation that the patient did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy?

☐ Yes ☐ No

Q5. Is Arikayce being prescribed by or in consultation with a pulmonologist or infectious disease specialist?

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Member Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Requested Duration: ☐ 12 months	☐ Other
Q7. Additional Information:	

Prescriber Signature _____ Date _____

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