



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Diacomit - 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: <input type="checkbox"/> 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 Dravet Syndrome (DS)?

Yes No

Q2. Is Diacomit being prescribed by or in consultation with a neurologist?

Yes No

Q3. Is there documentation of an inadequate response, intolerance, or contraindication to at least two of the following: clobazam, valproic acid derivatives, topiramate, levetiracetam, zonisamide, clonazepam, ethosuximide, pharmaceutical grade cannabidiol?

Yes No

Q4. Requested Duration:

12 months Other

Q5. Additional Information:



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Diacomit - 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:
---------------------	-------------------------

Prescriber Signature

Date

v2026