Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Kerendia - 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. Have all potential contraindications (concomitant treatment with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin), adrenal insufficiency, GFR less than 25 mL/min, and baseline serum potassium level greater than 5 mEq/L) been excluded?

☐ Yes ☐ No

Q2. Does the patient have chronic kidney disease associated with type 2 diabetes (CKD with T2D) with documentation attached?

☐ Yes ☐ No

Q3. Will the patient continue therapy with an ACE or ARB at maximally tolerated doses for diabetic nephropathy, or is there an intolerance or contraindication to these therapies?

☐ Yes ☐ No

Q4. Does the patient have heart failure with left ventricular ejection fraction of 40% or greater?

☐ Yes ☐ No

Q5. Has the diagnosis been determined by one of the following tests with results attached: echocardiography, cardiac MRI, nuclear medicine scans (MUGA), cardiac catheterization?

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Member Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Will the patient continue therapy with one sodium-glucose co-transporter 2 (SGLT2) inhibitor at a maximally tolerated dose or is there an intolerance or contraindication to this therapy?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other:

Q8. Additional Information:

Prescriber Signature Date

v2026