Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

High Risk-Non-Benzo Sedative Hypnotics - 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 this an initial request for a high-risk medication? If YES, go to 3. If NO, go to 2.

☐ Yes ☐ No

Q2. Does the benefit continue to outweigh the potential risk of the high-risk medication?

☐ Yes ☐ No

Q3. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q4. Is there confirmation of the patient's diagnosis?

☐ Yes ☐ No

Q5. Is this high-risk medication being used for an FDA-approved indication?

☐ Yes ☐ No

Q6. Has a risk-versus-benefit assessment been completed for the high-risk medication?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q7. Is there confirmation that the benefit outweighs the risk for the high-risk medication?

☐ Yes ☐ No

Q8. Has the prescriber provided an attestation of intent to monitor and address treatment-related adverse events?

☐ Yes ☐ No

Q9. Is there documentation of an inadequate response or inability to tolerate at least one safer formulary alternative, such as trazodone, mirtazapine, ramelteon, or doxepin 3 mg or 6 mg?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months ☐ Other:

Q11. Additional Information:

_____ _____

Prescriber Signature Date

v2026