Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Revcovi - 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 the request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there documentation showing stabilization or improvement in immune status (such as infection rate, incidence and duration of hospitalization, performance status)?

☐ Yes ☐ No

Q3. Is there documentation of diagnosis as defined by one of the following: (1) documentation of absent or very low adenosine deaminase activity in red blood cells (less than 1 percent of normal) OR (2) molecular genetic testing confirming diagnosis?

☐ Yes ☐ No

Q4. Is there documentation of severely impaired immune function (e.g., lymphopenia, extensive dermatitis, persistent diarrhea, recurrent pneumonia, life threatening illness caused by opportunistic infections)?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q5. Are there notes showing the patient has failed or is not a candidate for hematopoietic cell transplantation (HCT)?

☐ Yes ☐ No

Q6. Is the drug being prescribed by or in consultation with an immunologist, hematologist, oncologist, or specialist in inherited metabolic disorders?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other:

Q8. Additional Information:

_____ _____

Prescriber Signature Date

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