



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Sodium Phenylbutyrate - 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.**

<p>Q1. Is the patient being treated for acute hyperammonemia in urea cycle disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the member have a diagnosis of urea cycle disorder involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS) confirmed by enzymatic, biochemical, or genetic testing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is sodium phenylbutyrate being used for chronic management?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the medication being prescribed by or in consultation with prescriber experienced in metabolic disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Requested Duration:</p> <p><input type="checkbox"/> 12 months <input type="checkbox"/> Other</p>

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Member Name:	Prescriber Name:
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Q6. Additional Information:

Prescriber Signature

Date

v2026