Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Medication - Antispasmodics

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 of a High-Risk Medication? If YES, go to 3. If NO, go to 2.

☐ Yes ☐ No

Q2. Has the prescriber provided an explanation that the benefit continues to outweigh the potential risk of the High-Risk Medication?

☐ Yes ☐ No

Q3. Is the patient 65 years of age or older? If YES, go to 4.

☐ Yes ☐ No

Q4. Are chart notes attached documenting an explanation of the risk versus benefit which shows the benefit outweighs the potential risk for the use of the high-risk medication? If YES, go to 5.

☐ Yes ☐ No

Q5. Has the prescriber provided an attestation of intent to monitor and address treatment-related adverse events? If YES, go to 6.

☐ Yes ☐ No

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Q6. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine) with the requested drug, has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient? (Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline). If YES or not applicable, go to 7.

☐ Yes ☐ No

Q7. Are chart notes attached documenting the patient has diarrhea? If YES, go to 8. If NO, go to 9.

☐ Yes ☐ No

Q8. Has the patient had an inadequate response or inability to tolerate at least one non-high risk formulary alternative, such as loperamide?

☐ Yes ☐ No

Q9. Are chart notes attached documenting the patient has nausea and vomiting? If YES, go to 10. If NO, go to 11.

☐ Yes ☐ No

Q10. Has the patient had an inadequate response or inability to tolerate at least one non-high risk formulary alternative, such as ondansetron or granisetron tablet?

☐ Yes ☐ No

Q11. Are chart notes attached documenting the medication is being used for a medically accepted indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q12. I have educated the member regarding the risks of taking multiple anticholinergic medications, and the member accepts these risks.

☐ Yes ☐ No

Q13. If applicable, I have consulted with the other prescribers involved in concomitant anticholinergic therapy for this member.

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☐ Yes ☐ No ☐ NA

Q14. I acknowledge, as the prescriber initiating or maintaining multiple anticholinergic medications, the risk of adverse event(s) associated with concurrent utilization.

☐ Yes ☐ No

Q15. Requested Duration:

☐ 12 months ☐ Other

Q16. Additional information:

Prescriber Signature

Date

v2026