Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Medication - Lorazepam

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 Lorazepam? 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 with concurrent opioid therapy?

☐ 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 profile which shows the benefit outweighs the potential risk for the use of the high-risk medication with concurrent opioid therapy? 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. [see Q12-Q14 for attestation]

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:**

☐ Yes ☐ No

Q6. Are chart notes attached documenting the patient has anxiety disorder? If YES, go to 7. If NO, go to 9.

☐ Yes ☐ No

Q7. Is the requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety? If YES, go to 10. If NO, go to 8.

☐ Yes ☐ No

Q8. Is documentation attached showing inadequate response, intolerance, or contraindication to AT LEAST ONE agent from EACH of the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs)? If YES, go to 10.

☐ Yes ☐ No

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

☐ Yes ☐ No

Q10. Is documentation attached showing inadequate response, intolerance, or contraindication to two non-high risk alternatives, such as trazodone, mirtazapine, doxepin 3 mg or 6 mg, ramelteon. If YES, go to 12.

☐ Yes ☐ No

Q11. Are chart notes attached documenting the patient is taking the requested medication for an FDA approved indication?

☐ Yes ☐ No

Q12. I have educated the member in regards to the risks of concurrent utilization of benzodiazepine and opioid therapy, and the member accepts these risks.

☐ Yes ☐ No

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Medication - Lorazepam

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:**

Q13. If applicable, I have consulted other prescribers involved in concurrent therapy and all prescribers involved agree to pursue concurrent opioid and benzodiazepine therapy for this member.

☐ Yes ☐ No ☐ NA

Q14. I acknowledge, as the prescriber initiating or maintaining concurrent benzodiazepine and opioid therapy, 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