



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

L-Glutamine Oral Powder - 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 a reauthorization request? If YES, go to 2. If NO, go to 3.

☐ Yes

☐ No

Q2. Is there confirmation of a positive clinical response?

☐ Yes

☐ No

Q3. Does the patient have a diagnosis of sickle cell disease? Chart notes must be attached. If YES, go to 4.

☐ Yes

☐ No

Q4. Is the request to reduce acute complications of sickle cell disease? If YES, go to 5.

☐ Yes

☐ No

Q5. Is there documentation of an inadequate response, intolerance, or contraindication to hydroxyurea OR documentation showing L-glutamine will be used in combination with hydroxyurea? If YES, go to 6.

☐ Yes

☐ No



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Member Name:	Prescriber Name:
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Q6. Is the requested dose within the FDA labeled dose? If YES, go to 7.

☐ Yes ☐ No

Q7. Will L-glutamine oral powder be prescribed by or in consultation with a hematologist or oncologist?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 12 Months ☐ Other

Q9. Additional Information:

Prescriber Signature

Date

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