



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Sodium Phenylbutyrate

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable)

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: 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 patient being treated for acute hyperammonemia in urea cycle disorders?

Yes checkbox

No checkbox

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?

Yes checkbox

No checkbox

Q3. Is sodium phenylbutyrate being used for chronic management?

Yes checkbox

No checkbox

Q4. Is the medication being prescribed by or in consultation with prescriber experienced in metabolic disorders?

Yes checkbox

No checkbox

Q5. Additional Information:



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Patient Name:	Prescriber Name:

Prescriber Signature

Date

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