

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Icatibant - 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 NOT	E: Any information (patient, pres	scriber, drug, labs) left blank, illegible, or	not attached WILL delay the review process.
Patient Name:		Prescriber Name:	
Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Line of Business:	□ Medicare	NPI:	State Lic ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility nam	e (if applicable):
	DITED REVIEW: By checking this box and nrollee or the enrollee's ability to regain		ur standard review timeframe may seriously jeopardize
Drug Name:			
Strength:			
Directions / SIG:			
Please attach	• •	including labs and information for the inswer the following questions and s	nis member that may support approval. ign.
Q1. Does the	patient have a documer	nted diagnosis of hereditary a	ngioedema (HAE)?
☐ Yes		□ No	
Q2. Is the pat	ient 18 years of age or o	older?	
☐Yes		□ No	
Q3. Is the pat angioedema?	•	ugs indicated for acute treatm	ent of hereditary
☐ Yes		☐ No	
Q4. Is icatiba	nt being the prescribed I	by or in consultation with an a	llergist or immunologist?
☐ Yes		□No	
Q5. Additiona	Information:		
Q6. Requeste	ed Duration:		

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Patient Name:	Prescriber Name:		
☐ 12 Months			
Prescriber Signature	Date 2024 Medicare Prior Authorization Request		