Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Dimethyl Fumarate

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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. Request type:

☐ Initial Therapy - Go to 2 ☐ Continuation of Therapy - Go to 6

Q2. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q3. Is the requested medication being used concomitantly with other disease modifying multiple sclerosis agents? Note: Ampyra and Nuedexta are not disease modifying.

☐ Yes ☐ No

Q4. Does the patient have one of the following diagnoses:
A) Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
B) Clinically isolated syndrome?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. For continuation, is the patient experiencing disease stability or improvement while receiving the medication?

☐ Yes ☐ No

Q6. Additional Information:

_____ _____

Prescriber Signature Date

v2025