Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

High Risk Meds - 1st Gen Antihistamine - 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.

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 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 the patient 65 years of age or older?

☐ Yes ☐ No

Q2. Is this High Risk Medication being used for a medically accepted indication?

☐ Yes ☐ No

Q3. What is the diagnosis?

Q4. Has a risk-versus-benefit assessment been completed for the High Risk Medication?

☐ Yes ☐ No

Q5. Has the patient been counseled on the potential side effects and risks of the requested High Risk Medication?

☐ Yes ☐ No

Q6. Does the benefit outweigh the potential risks?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed for the treatment of allergic conditions?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

Prescriber Signature

Date