Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Inhalation Sol-Mucolytics - 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 using the requested drug with a nebulizer?

☐ Yes ☐ No

Q2. Is the request for dornase alpha (Pulmozyme)?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of cystic fibrosis (ICD-10 diagnosis code E84.0)?

☐ Yes ☐ No

Q4. Is the request for acetylcysteine?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of persistent thick or tenacious pulmonary secretions associated with ICD-10 diagnosis codes A22.1, A37.01, A37.11, A37.81, A37.91, A48.1, B25.0, B44.0, B77.81, E84.0, J09.X1-J09.X3, J09.X9, J10.00, J10.01, J10.08, J10.1, J10.2, J10.81-J10.83, J10.89, J11.00, J11.08, J11.1, J11.2, J11.81-J11.83, J11.89, J12.0-J12.3, J12.81, J12.89, J12.9, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3-J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9, J40, J41.0, J41.1, J41.8, J42, J43.0-J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990,

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Patient Name:	**Prescriber Name:**

J45.991, J45.998, J47.0, J47.1,J47.9, J60, J61, J62.0, J62.8, J63.0-J63.6, J64, J65, J66.0-J66.2, J66.8, J67.0-J67.9, J68.0-J68.4, J68.8, J68.9, J69.0, J69.1, J69.8, J70.0-J70.5, J70.8, J70.9?

☐ Yes ☐ No

Q6. Requested Duration:

☐ 12 Months ☐ Other:

Q7. Additional Information:

_____ _____

Prescriber Signature Date

2024 Medicare Prior Authorization Request