

## **MEDICARE ADVANTAGE** PRIOR AUTHORIZATION REQUEST FORM

Cerdelga - 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

PLEASE NOTE: Any Informa	tion (patient, prescriber, c	arug, iabs) ieπ biank, illegible	, or not attached WILL delay the review process.
Member Name:		Prescriber Name:	
Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Line of Business:   Medicare A	dvantage	NPI:	State Lic ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By the life or health of the enrollee or the enro			2 hour standard review timeframe may seriously jeopardize
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent	-	ng labs and information for the following questions ar	or this member that may support approval.
Q1. Does the patient have patient is a CYP2D6 extermetabolizer (PM) as determined to the control of the patient have patient as a cyproper patient of the patient have patient as a cyproper patient have patient hav	ensive metabolizer	(EM), intermediate n	
☐ Yes		□No	
Q2. Is the patient 18 yea	rs of age or older?		
☐ Yes		□ No	
Q3. Requested Duration:			
☐ 12 Months		☐ Other:	
Q4. Additional Informatio	n:		
Prescriber S	 signature		Date
			v2025

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