Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Drizalma Sprinkle - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 administration via nasogastric tube required or is there documentation showing inability to or difficulty with swallowing solid dosage forms?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of MDD including documentation of an inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., fluoxetine solution, citalopram solution, escitalopram solution, sertraline oral concentrate, paroxetine suspension)?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of GAD including documentation of an inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., escitalopram solution, paroxetine suspension)?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of DPNP including documentation of an inadequate response, intolerance, or contraindication to gabapentin solution?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q5. Does the patient have a diagnosis of fibromyalgia including documentation of an inadequate response, intolerance, or contraindication to gabapentin solution?

☐ Yes ☐ No

Q6. Does the patient have a documented diagnosis of chronic musculoskeletal pain?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the patient 7 years of age or older?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

Prescriber Signature

Date

v2025