

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Sympazan - 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: | 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: | City, State ZIP: | | |
| Primary Phone: | | Specialty/facility nam | Specialty/facility name (if applicable): | | |
| | <u>DITED REVIEW</u> : By checking this box and signir nrollee or the enrollee's ability to regain maxin | | our standard review timeframe may seriously jeopardize | | |
| 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 Sympazan being used for a medically accepted indication not otherwise excluded from Part D? | | | | | |
| ☐ Yes | | □No | | | |
| Q2. Is the par | tient 2 years of age or older? |) | | | |
| ☐ Yes | | □No | | | |
| Q3. Is Sympazan prescribed by or in consultation with a neurologist? | | | | | |
| ☐ Yes | | □No | | | |
| Q4. Is there of clobazam? | locumentation attached of ar | n inadequate response o | inability to tolerate generic | | |
| ☐ Yes | | □ No | | | |
| | locumentation attached show pileptic drugs? | wing that Sympazan will b | pe used as adjunctive therapy | | |
| ☐ Yes | | □ No | | | |

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|--|------------------|------|-------|--|
| Member Name: | Prescriber Name: | | | |
| Q6. Requested Duration: | | | | |
| ☐ 12 Months | ☐ Other: | | | |
| Q7. Additional Information: | | | | |
| | | | | |
| | | | | |
| Prescriber Signature | | Date | | |
| | | | v2025 | |

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