



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

High Risk Meds - Skeletal Muscle Relaxant-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.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, 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.

Form with fields: 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? [Note: The Prior Authorization requirement only applies to patients 65 years of age or older. Prior Authorization is not required for patients under 65 years of age.]

Yes No

Q2. Is this High Risk Medication being used for a medically accepted indication? Please list indication for use and the patient's diagnosis.

Yes No

Q3. Has a risk-versus-benefit assessment been completed for the High Risk Medication?

Yes No

Q4. Has the patient been counseled on the potential side effects and risks of the requested High Risk Medication?

Yes No

Q5. Does the benefit outweigh the potential risk?

Yes No

Q6. Requested Duration:



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Patient Name:	Prescriber Name:
<input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q7. Additional Information:	

Prescriber Signature

Date

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