

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Spritam - Step Therapy - 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

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):
he life or health of the enrollee or the enrollee's ability to re Drug Name: Strength:	and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize gain maximum function.
Directions / SIG:	
Pleas	ry including labs and information for this member that may support approval. e answer the following questions and sign.
Q1. Has the patient tried formulary	evetiracetam 100 mg/ml solution?
☐ Yes	□ No
Q2. Requested Duration:	
☐ 12 Months	☐ Other:
Q3. Additional Information:	
Prescriber Signature	Date
•	v2025

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