Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Cystadane (betaine anhydrous) - Exchange

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 this an initial or continuation request?

☐ Initial - Go to 2 ☐ Continuation for homocystinuria - Go to 6

Q2. What is the diagnosis?

☐ Homocystinuria – Go to 3 ☐ Methylmalonic acidemia with homocystinuria – Go to 5

Q3. For homocystinuria, does the member have one of the following types of homocystinuria and the diagnosis was confirmed by enzyme assay or genetic testing? Please attach documentation. (Please select the type)

☐ Cystathionine beta-synthase (CBS) deficiency
☐ 5,10-methylenetetrahydrofolate reductase (MTHFR) deficiency
☐ Cobalamin cofactor metabolism (cbl) defect
☐ Not applicable

Q4. If the member has CBS deficiency, will plasma methionine concentrations be monitored and kept below 1,000 micromol/L through dietary modification, and if necessary, a reduction in Cystadane dose?

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Member Name:	**Prescriber Name:**

☐ Yes ☐ No ☐ NA

Q5. Does the patient have a documented diagnosis of methylmalonic acidemia with homocystinuria? Please attach documentation.

☐ Yes ☐ No

Q6. For reauthorization for homocystinuria, are BOTH of the following criteria met?
A) The total homocysteine level is undetectable or present only in small amounts, OR there is a substantial decrease in homocysteine levels and the dose will be increased until maximum tolerability or plasma total homocysteine is undetectable or present in only small amounts.
B) If the member has CBS deficiency, plasma methionine concentrations will be monitored and kept below 1,000 micromol/L through dietary modification, and if necessary, a reduction in Cystadane dose.

☐ Yes ☐ No

Q7. For reauthorization for methylmalonic acidemia with homocystinuria, is there documentation showing patient is experiencing benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2025