



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Plegridy**

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the 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.**

<p><b>Q1. Request Type:</b></p> <p><input type="checkbox"/> Initial - Go to 2 <span style="margin-left: 200px;"><input type="checkbox"/> Continuation - Go to 5</span></p>
<p><b>Q2. Is the requested medication prescribed by or in consultation with a neurologist?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 150px;"><input type="checkbox"/> No</span></p>
<p><b>Q3. Is the requested medication being used concomitantly with other disease modifying multiple sclerosis agents (Note: Ampyra and Nuedexta are not disease modifying)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 150px;"><input type="checkbox"/> No</span></p>
<p><b>Q4. Does the patient have one of the following diagnoses: A) Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse); B) clinically isolated syndrome?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 150px;"><input type="checkbox"/> No</span></p>
<p><b>Q5. For continuation, is the patient experiencing disease stability or improvement while receiving the medication?</b></p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025