Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Signifor

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 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.

Q1. Is this an initial or continuation request?

☐ Initial - Go to 2 ☐ Continuation - Go to 4

Q2. Have pretreatment cortisol levels as measured by one of the following tests been submitted:
A) Urinary free cortisol (UFC)
B) Late-night salivary cortisol (LNSC)
C) 1 mg overnight dexamethasone suppression test (DST)
D) Longer, low dose DST (2 mg per day for 48 hours)?

☐ Yes ☐ No

Q3. Is the requested medication being used for treatment of Cushing's disease in patients who either have had surgery that was not curative OR for members who are not candidates for surgery?

☐ Yes ☐ No

Q4. For continuation, have labs been submitted showing current cortisol level has decreased from baseline as measured by one of the following tests:
A) Urinary free cortisol (UFC)

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Patient Name:	**Prescriber Name:**

B) Late-night salivary cortisol (LNSC)
C) 1 mg overnight dexamethasone suppression test (DST)
D) Longer, low dose DST (2 mg per day for 48 hours)?

☐ Yes ☐ No

Q5. Is the patient showing improvement in signs or symptoms of the disease?

☐ Yes ☐ No

Q6. Additional Information:

_____ _____

Prescriber Signature Date

v2025