Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Xermelo

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 the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Is this a renewal request or continuation of therapy request? If Yes, go to 6.

☐ Yes ☐ No

Q3. Is documentation of the patient's diagnosis included showing a diagnosis of carcinoid syndrome diarrhea inadequately controlled (at least 4 bowel movements per day) despite a 3-month trial of somatostatin analog therapy?

☐ Yes ☐ No

Q4. Are there records confirming concurrent SSA therapy?

☐ Yes ☐ No

Q5. Is the medication being prescribed by or in consultation with a specialist (such as oncologist, endocrinologist, or gastroenterologist)?

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Xermelo

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:**

☐ Yes	☐ No
Q6. Is documentation attached showing a positive clinical response to therapy?	
☐ Yes	☐ No
Q7. Additional Information:	
Q8. Duration:	
☐ 12 months	☐ Other

Prescriber Signature _____ Date _____

v2025