

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Cystaran - 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 NO	TE: Any information (patient, prescriber, drug, la	abs) left blank, illegil	ble, 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:	City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):		
	<u>DITED REVIEW</u> : By checking this box and signing below, I enrollee or the enrollee's ability to regain maximum funct		e 72 hour standard review timeframe may seriously jeopardize	
Drug Name:				
Strength:				
Directions / SIG:	<u> </u>			
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. Does the patient have a diagnosis of cystinosis? Please provide documentation.				
☐ Yes		□No		
Q2. Does the patient have corneal cystine crystal accumulation? Please provide documentation.				
□Yes		□ No		
Q3. Requested Duration:				
☐ 12 months		☐ Other		
Q4. Additional Information:				
Prescriber Signature			Date v2025	

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