

## MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Gattex - 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 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	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box he life or health of the enrollee or the enrollee's ability to reg		ur standard review timeframe may seriously jeopardize	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical histo Please	ry including labs and information for the answer the following questions and s		
Q1. Is this a request for continuation	ነ?		
☐ Yes	□No		
Q2. Is there documentation showing dependent on parenteral support?	g a diagnosis of short bowel syr	ndrome and patient is	
☐ Yes	□ No		
Q3. Is there documentation of reduc	ction in parenteral support?		
☐Yes	□ No		
Q4. Requested Duration:			
☐ 12 Months	☐ Other:		
Q5. Additional Information:			



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Member Name:	Prescriber Name:
Prescriber Signature	Date
	v2025

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