



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

High Risk-Non-Benzo Sedative Hypnotics - 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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	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 applying the 72 hour 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. Is this an initial request of a High Risk Medication?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q2. Does the benefit continue to outweigh the potential risk of the High Risk Medication?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q3. Is the patient 65 years of age or older?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q4. Is this High Risk Medication being used for an FDA-accepted indication?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q5. What is the patient's diagnosis?</b></p>
<p><b>Q6. Has a risk-versus-benefit assessment been completed for the High Risk Medication?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Member Name:</b>	<b>Prescriber Name:</b>
Q7. Does the benefit outweigh the potential risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Has the patient had an inadequate response or inability to tolerate two safer formulary alternatives, such as trazadone, ramelteon, or doxepin (generic Silenor)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other	
Q10. Additional Information:	

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

\_\_\_\_\_  
Date

v2025