MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Medication - Anticholinergics - 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 (if applicable):**	

☐ 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.

Q1. Is this an initial request of a High Risk Medication? If YES, go to 3.

☐ Yes ☐ No

Q2. Does the benefit continue to outweigh the potential risk of the High Risk Medication?

☐ Yes ☐ No

Q3. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q4. What is the diagnosis?

Q5. Has a risk-versus-benefit assessment been completed for the High Risk Medication?

☐ Yes ☐ No

Q6. Does the benefit outweigh the potential risks?

☐ Yes ☐ No

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Q7. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine) with the requested drug, has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient?

☐ Yes ☐ No ☐ NA

Q8. Is the requested drug being prescribed for the treatment of allergic conditions?

☐ Yes ☐ No

Q9. Has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray?

☐ Yes ☐ No

Q10. Is this High Risk Medication being used for an FDA approved indication?

☐ Yes ☐ No

Q11. Requested Duration

☐ 12 months ☐ Other

Q12. Additional Information

______________________________ ____________________

Prescriber Signature Date

v2025

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