Jefferson Health Plans

# *MEDICARE ADVANTAGE*
## *PRIOR AUTHORIZATION REQUEST FORM*

High Risk Meds-Butalbital Combinations - 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?

☐ 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?
Note: The Prior Authorization requirement only applies to patients 65 years of age or older. Prior Authorization is not required for patients under 65 years of age.

☐ Yes ☐ No

Q4. Is this High Risk Medication being used for a medically accepted indication?

☐ Yes ☐ No

Q5. What is the patient's diagnosis?

Q6. Has a risk-versus-benefit assessment been completed for the High Risk Medication?

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|---|---|

☐ Yes ☐ No

Q7. Does the benefit outweigh the potential risk?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 12 months ☐ Other:

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2025