2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Kynmobi Sublingual Film - 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.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business:	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 the life or health of the enrollee or the enrollee's ability to	ox and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize regain maximum function.
Drug Name:	
Strength:	
Directions / SIG:	
* *	story including labs and information for this member that may support approval.
Q1. Does the patient have a docu off episodes?	mented diagnosis of Parkinson's disease (PD) with intermittent
Q2. Is Kynmobi being prescribed	oy or in consultation with a neurologist?
□Yes	□ No
two conventional oral therapies (e amantadine, selegiline, rasagaline	inadequate response, intolerance, or contraindication to at least .g carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, e, trihexyphenidyl, benztropine, entacapone, tolcapone)?
Yes	□ No
Q4. Duration:	
☐ 12 months	☐ Other
Q5. Additional Information:	
Prescriber Signature	Date

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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Patient Name:		Prescriber Name:

2024 Medicare Prior Authorization Request