Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Cerdelga

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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. Request type:

☐ Initial Therapy - Go to 2 ☐ Continuation of Therapy - Go to 4

Q2. Has the diagnosis of Gaucher disease been confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing? Please attach documentation.

☐ Yes ☐ No

Q3. Is the patient a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer as detected by an FDA-cleared test? Please attach results.

☐ Yes ☐ No

Q4. For reauthorization, is there confirmation that the patient is not experiencing an inadequate response or any intolerable adverse events from therapy?

☐ Yes ☐ No

Q5. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2025