2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Recorlev - 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.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: ☐ Medicare	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 the request for Recorlev for continuation?

☐ Yes - go to 2 ☐ No - go to 3

Q2. Has the patient had a positive clinical response with Recorlev?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of Cushing's Syndrome?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the medication being prescribed by, or consultation with, an endocrinologist?

☐ Yes ☐ No

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Q6. Are notes attached showing the member is being treated for endogenous hypercortisolemia (e.g. pituitary tumor, ectopic tumor, adrenal adenoma or carcinoma)?

☐ Yes ☐ No

Q7. Are notes attached showing one of the following: A) the member is not a candidate for surgery -or- B) the member has recurrent hypercortisolism after initial surgery?

☐ Yes ☐ No

Q8. Is there documentation showing a trial of, intolerance to, or contraindication to ketoconazole?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 months ☐ Other

Q10. Additional Information:

Prescriber Signature

Date

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