



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Kerendia - 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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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. Does the member have chronic kidney disease associated with type 2 diabetes (CKD with T2D) (documentation attached)?

Yes  No

Q2. Have all potential contraindications (concomitant treatment with strong CYP3A4 inhibitors [e.g., itraconazole, clarithromycin], adrenal insufficiency, GFR less than 25 mL/min, serum potassium level greater than 5 mEq/L) been excluded?

Yes  No

Q3. Will the member continue therapy with an ACE or ARB at maximally tolerated doses for diabetic nephropathy, or is there an intolerance or contraindication to these therapies?

Yes  No

Q4. Has the patient had a documented inadequate response, intolerance or contraindication to one sodium-glucose co-transporter 2 (SGLT2) inhibitor used for chronic kidney disease (e.g., Farxiga)?

Yes  No



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Kerendia - 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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>
Q5. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q6. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025