Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Cinryze - 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. Has the patient been previously approved for Cinryze?

☐ Yes ☐ No

Q2. Is there confirmation that the patient has had a reduction in severity or duration of attacks?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q5. Is Cinryze being prescribed by or in consultation with an allergist or immunologist?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other:

Q8. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request