2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Wakefulness-Promoting Agents - 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.

| | Burnerally and Manner | |
|--|--|--|
| 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, the life or health of the enrollee or the enrollee's ability to regain maximum func | I certify that applying the 72 hour standard review timeframe may seriously jeopardize tion. | |
| 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 patient 17 years of age or older? | | |
| ☐ Yes | □ No | |
| Q2. Has the patient been prescribed armodafinil by or in consultation with a sleep specialist or neurologist? | | |
| ☐ Yes | □ No | |
| Q3. Does the patient have a confirmed diagnosis of narcolepsy? Please attach sleep study. | | |
| ☐ Yes | □ No | |
| Q4. Does the patient have a confirmed diagnosis of shift work disorder? Please attach chart notes supporting diagnosis. | | |
| ☐ Yes | □ No | |
| Q5. Does the patient have obstructive sleep apnea? Please attach sleep study. | | |
| □Yes | □ No | |

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Wakefulness-Promoting Agents - 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 |): |
|-----------------------------|-----------------|---|
| Q6. Additional Information: | | |
| | | |
| Q7. Requested Duration: | | |
| ☐ 12 Months | ☐ Other: | |
| | | |
| Prescriber Signature | | Date |
| | | 2024 Medicare Prior Authorization Request |