2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Ztalmy - 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 Nam	Prescriber Name:	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:		
Line of Business:	e	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:		Specialty/facility	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW he life or health of the enrollee or th			e 72 hour standard review timeframe may seriously jeopardize	
Drug Name:				
Strength:				
Directions / SIG:				
Please attach any perti		ding labs and information r the following questions	for this member that may support approval. and sign.	
Q1. Does the patient deficiency disorder (0		diagnosis of cyclin-d	ependent kinase-like 5 (CDKL5)	
☐ Yes		□ No		
Q2. Is Ztalmy being μ	orescribed by, or in co	onsultation with, a ne	urologist?	
☐ Yes		□ No		
Q3. Requested Dura	tion:			
☐ 12 months		☐ Other		
Q4. Additional Inform	ation:			
Prescriber Signature			Date	
			2024 Medicare Prior Authorization Request	

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