## 2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Carglumic Acid - 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.

Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:	Office Contact:	
Line of Business: □ Medicare		NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility name	Specialty/facility name (if applicable):	
the life or health of the e	DITED REVIEW: By checking this box a nrollee or the enrollee's ability to rega		ır standard review timeframe may seriously jeopardize	
Drug Name: Strength:				
Directions / SIG:				
Please attach	* -	•	is member that may support approval.	
Q1. Does the member have a diagnosis of acute hyperammonemia due to NAGS deficiency, PA, or MMA?				
☐ Yes		□ No		
	entation attached show are for treatment?	ving carglumic acid is being use	ed as adjunctive therapy to	
□Yes		□ No	□ No	
Q3. Does the member have a diagnosis of chronic hyperammonemia due to NAGS deficiency?  ☐ Yes			ia due to NAGS deficiency?	
Q4. Is docum	entation attached show	ring carglumic acid is being use	ed for maintenance therapy?	
□Yes		□ No		
Q5. Additiona	l Information:			
Q6. Requeste	ed Duration:			
☐ 12 months		☐ Other		

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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Patient Name:	Prescriber Name:		
Prescriber Signature	Date		
	2024 Medicare Prior Authorization Request		