2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Diacomit - 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 nam	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box an the life or health of the enrollee or the enrollee's ability to regain		ur standard review timeframe may seriously jeopardize	
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 patient have a documented diagnosis of Dravet syndrome (DS)?			
☐ Yes	□ No		
Q2. Is Diacomit being prescribed by or in consultation with a neurologist or epileptologist?			
☐ Yes	☐ No		
Q3. Is there documentation of an inadequate response or intolerance to at least two agents to treat Dravet syndrome: such as clobazam, valproic acid derivatives, topiramate, levetiracetam, cannabidiol (pharmaceutical)?			
☐ Yes	☐ No		
Q4. Requested Duration:			
☐ 12 months	☐ Other		
Q5. Additional Information:			

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
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