



High Risk Meds - 1st Gen Antihistamine - 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: Medica	re NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
	<u>W</u> : By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize le enrollee's ability to regain maximum function.	
Drug Name:		
Strength:		
Directions / SIG:		
Please attach any nor	nent medical history including labs and information for this member that may support approval.	
Flease attach any per	Please answer the following questions and sign.	
Q1. Is the patient 65	years of age or older?	
☐ Yes	□ No	
Q2. Is this High Risl	Medication being used for a medically accepted indication?	
□ Yes	□ No	
Q3. What is the diag	nosis?	
Q4. Has a risk-versus-benefit assessment been completed for the High Risk Medication?		
□ Yes	□No	
Q5. Has the patient Risk Medication?	peen counseled on the potential side effects and risks of the requested High	
□ Yes	□No	
Q6. Does the benef	outweigh the potential risks?	
□ Yes	□No	
Q7. Is the requested	drug being prescribed for the treatment of allergic conditions?	

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Patient Name:	Prescriber Name:		
□Yes	□ No		
Q8. Has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratedine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray?			
☐ Yes	□No		
Q9. Requested Duration:			
☐ 12 Months	☐ Other:		
Q10. Additional Information:			
Prescriber Signature	Date		
	2024 Medicare Prior Authorization Request		