2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Kesimpta - 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:	<u> </u>	
			Dhamai	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:		
Line of Business:	□ Medicare	NPI:	State Lic ID:	
Address:		Address:	Address:	
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility name	Specialty/facility name (if applicable):	
	<u>DITED REVIEW</u> : By checking this box an enrollee or the enrollee's ability to regain		r standard review timeframe may seriously jeopardize	
Drug Name:				
Strength:				
Directions / SIG:				
Please attach		r including labs and information for thi answer the following questions and sig	is member that may support approval. gn.	
	nentation provided showi agents used to treat MS	ing an inadequate response, co ?	ontraindication or intolerance	
☐ Yes		□ No		
Q2. Does the	e member have an active	e HBV infection?		
☐ Yes		□ No		
Q3. Is the pro	ovider a neurologist?			
☐Yes		□ No		
Q4. Request	ed Duration:			
☐ 12 months		☐ Other:		
Q5. Additiona	al Information:			

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