2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Ravicti - 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 name (if applicable):

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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. Is the patient being treated for N-acetylglutamate synthase (NAGS) deficiency?		
	□ No	
Q2. Does the patient have a documentedation diagnosis of urea cycle disorder confirmed by enzymatic, biochemical, or genetic testing (must be attached)?		
□ Yes	□ No	
Q3. Is the patient being treated for acute hyperammonemia?		
□ Yes	□ No	
Q4. Has the patient had an inadequate response, intolerance, or contraindication to sodium phenylbutyrate?		
	□ No	
Q5. Is Ravicti being prescribed by or in consultation with an appropriate specialist such as a metabolic or medical genetic specialist?		

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Patient Name:	Prescriber Name:	
□ Yes	🗆 No	
Q6. Is there cconfirmation that ammonia concentration and serum amino acids are being monitored to ensure positive clinical treatment response?		
□ Yes	□ No	
Q7. Additional Information:		
Q8. Requested Duration:		
☐ 12 Months	□ Other	

Prescriber Signature

Date

2024 Medicare Prior Authorization Request

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