## 2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Sympazan - 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.

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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):	
	<u>DITED REVIEW</u> : By checking this box and signing below, I enrollee or the enrollee's ability to regain maximum funct	certify that applying the 72 hour standard review timeframe may seriously jeopardize ion.	
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 Sympazan being used for a medically accepted indication not otherwise excluded from Part			
D?		□ No	
Q2. Is the par	tient 2 years of age or older?		
☐ Yes		□ No	
Q3. Is Sympa	azan prescribed by or in consultatio	n with a neurologist or epileptologist?	
☐ Yes		□ No	
Q4. Is there of other antiepile		at Sympazan will be used as adjunctive therapy to	
□Yes		□ No	
Q5. Additiona	al Information:		
Q6. Duration:			
☐ 12 months		☐ Other:	

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
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