

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Vigadrone (vigabatrin) powder

Fax back to: (833) 605-4407 Phone: (215) 991-4300

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.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, meglible, or not attached will delay the review process.			
Patient Name:	Prescriber Name:	Prescriber Name:	
Member Number:	Fax: Phone:	Fax: Phone:	
Date of Birth:	Office Contact:		
Line of Business: □ Exchange - PA	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box an the enrollee or the enrollee's ability to regain maximum function		w timeframe may seriously jeopardize the life or health of	
Drug Name:			
Strength:  Directions / SIG:			
Directions / SIG.			
Please attach any pertinent medical history Please a	including labs and information for the inswer the following questions and s		
Q1. What is the diagnosis?			
☐ Infantile spasms	☐ Complex pa	rtial seizures	
Q2. Is this an initial or continuation re	quest?		
☐ Initial	☐ Continuation	n	
Q3. For infantile spasms in members diagnosis?	less than 2 years of age, is th	ere documentation of the	
☐ Yes	☐ No		
Q4. For complex partial seizures, has alternative treatments for complex pa		e response to at least two	
☐ Yes	□No		
Q5. For reauthorization for infantile specific from vigabatrin therapy?	pasms, has the patient shown	substantial clinical benefit	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Vigadrone (vigabatrin) powder

Fax back to: (833) 605-4407 Phone: (215) 991-4300

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:
☐ Yes	□No
Q6. For reauthorization for complete benefit from vigabatrin therapy?	ex partial seizures, has the patient shown substantial clinical
☐ Yes	□ No
Q7. Additional Information:	
Prescriber Signature	Date
	2024 Prior Authorization Reque