

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Carglumic Acid**

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.

Patient 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 (if applicable):		
REQUEST FOR EXPEDITED REVIEW: By checking this box and the enrollee or the enrollee's ability to regain maximum function.	signing below, I certify that the standard rev	view timeframe may seriously jeopardize the life or health o	
Drug Name:			
Strength:			
Directions / SIG:			
	swer the following questions and	sign.	
Q1. Does the member have a diagnos or MMA?	is of acute hyperammonem	nia due to NAGS deficiency, PA,	
☐ Yes	□No		
Q2. Is documentation attached showin standard of care for treatment?	g carglumic acid is being u	sed as adjunctive therapy to	
☐ Yes	□ No		
Q3. Does the member have a diagnos	is of chronic hyperammone	emia due to NAGS deficiency?	
☐ Yes	□ No		
Q4. Is documentation attached showin	g carglumic acid is being u	sed for maintenance therapy?	
☐ Yes	□ No		
Q5. Additional Information:			

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

- 127.02 No. 121.7 My morniation (patients) processed, and g, 162.0 Mark, mogazio, or not attached the 167.0 My		
Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
	2024 Prior Authorization Reques	