

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

**Cystagon** 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.

Γ	bs) left blank, megible, or not attached WILL delay the review process.		
Patient Name:	Prescriber Name:		
Member Number:	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):		
☐ <u>REQUEST FOR EXPEDITED REVIEW</u> : By checking this box and signing below, I the enrollee or the enrollee's ability to regain maximum function.	certify that the standard review timeframe may seriously jeopardize the life or health o		
Drug Name:			
Strength:			
Directions / SIG:			
	s and information for this member that may support approval. owing questions and sign.		
	owing questions and sign.		
Q1. Request type:			
☐ Initial Therapy - Go to 2	☐ Continuation of Therapy - Go to 4		
Q2. Does the patient have a diagnosis of cysting cystine concentration in leukocytes or by genetic	· ·		
☐ Yes	□ No		
Q3. Will Cystagon be used in combination with F	Procysbi?		
□Yes	□ No		
Q4. For reauthorization, do lab results or chart n (e.g., improvement, stabilization, or slowing of dicalculated creatinine clearance, leukocyte cystin [height])?	sease progression for serum creatinine,		
☐ Yes	□ No		
Q5. Additional Information:			

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TELACE NOTE. Any information (patient, prescriber, drug, labs) left blank, inegible, or not attached with active process.				
Patient Name:		Prescriber Name:		
				]
				J
Prescriber Signature	e		Date	-
			2024 Prior Authorization Reques	t