

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Kesimpta

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:	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):				
REQUEST FOR EXPEDITED REVIEW: By checking this be the enrollee or the enrollee's ability to regain maximum fu	x and signing below, I certify that the standard review timeframe may seriously jeopardize the life or heal ction.	th of			
Drug Name:					
Strength:					
Directions / SIG:					
	ory including labs and information for this member that may support approval. se answer the following questions and sign.				
Q1. Is documentation provided sh to 2 different agents used to treat	owing an inadequate response, contraindication or intolerance MS?				
☐ Yes	□ No				
Q2. Does the member have an ac	ive HBV infection?				
☐ Yes	□ No				
Q3. Is the provider a neurologist?					
☐ Yes	□ No				
Q4. Additional Information:					
Prescriber Signature	Date				
	2024 Prior Authorization Requ	est			

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ı	Patient Name:			Prescriber Name:		