

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Nitisinone

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, prescri	per, drug, labs) left blank, illegible, 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):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and sign the enrollee or the enrollee's ability to regain maximum function.	ning below, I certify that the standard review timeframe may seriously jeopardize the life or healt	th of
Drug Name:		
Strength:		
Directions / SIG:		
	luding labs and information for this member that may support approval.	_
Q1. Request Type:		
☐ Initial - Go to 2	☐ Continuation - Go to 4	
	of hereditary tyrosinemia type 1 (HT-1) confirmed by accinylacetone in urine) or DNA testing? Please submit	
☐ Yes	□ No	
Q3. Is the requested medication being υ phenylalanine?	sed as an adjunct to dietary restriction of tyrosine and	
☐ Yes	□No	
Q4. For reauthorization, is there confirm response from therapy?	ation that the patient is experiencing beneficial clinical	
☐Yes	□ No	
Q5. Additional Information:		\neg

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
	2024 Prior Authorization Request	