Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Orilissa

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:**
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 signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug being prescribed for the management of moderate to severe pain associated with endometriosis? Please attach confirmation of diagnosis.

☐ Yes ☐ No

Q2. Is the requested drug prescribed at a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. Does the patient have a history of therapeutic failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs), AND therapeutic failure (based on a 3-month trial), contraindication, or intolerance to oral contraceptives?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is the medication being prescribed by or in consultation with an obstetrics/gynecologist (OB/GYN) or reproductive endocrinologist?

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature _____ Date _____

2024 Prior Authorization Request