

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Sirturo

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.

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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 nar	ne (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing belothe enrollee or the enrollee's ability to regain maximum function.	ow, I certify that the standard revi	ew timeframe may seriously jeopardize the life or health of	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical history including	labs and information for following questions and		
Q1. Is the requested drug being prescribed as pulmonary multi-drug resistant tuberculosis (N	•	therapy in a patient with	
☐ Yes	□ No		
Q2. Can another effective treatment regimen	be used instead of S	Sirturo (bedaquiline)?	
☐ Yes	□No		
Q3. Is the requested drug being prescribed for treatment-intolerant/nonresponsive multidrug-		, , ,	
☐ Yes	□No		
Q4. Is the requested drug being prescribed as and Zyvox (linezolid)?	s part of a combination	on regimen with Pretomanid	
□Yes	□No		
Q5. Additional Information:			

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Patient Name:	Prescriber Name:	Prescriber Name:	
Prescriber Signature	Date		
	2024 Prior Au	thorization Request	