

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Rufinamide - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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.

Patient Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicab	ile):
REQUEST FOR EXPEDITED REVIEW: By checking this boothe life or health of the enrollee or the enrollee's ability to re	x and signing below, I certify that applying the 72 hour standard revie egain maximum function.	ew timeframe may seriously jeopardize
Drug Name:		
Strength:		
Directions / SIG:	-	
	ory including labs and information for this member the answer the following questions and sign.	hat may support approval.
Q1. Does the patient have a docun	nented diagnosis of Lennox-Gastaut Syndr	rome (LGS)?
☐ Yes	□ No	
Q2. Is rufinamide being prescribed	by or in consultation with a neurologist or	epileptologist?
☐ Yes	□ No	
	nadequate response, intolerance, or contra derivatives, lamotrigine, clobazam, topiram	
☐ Yes	□ No	
Q4. Duration		
☐ 12 months	☐ Other	
Q5. Additional Information:		

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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