Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

CGRP Antagonists

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. Does the patient have at least 4 migraine days per month?

☐ Yes ☐ No

Q2. Does the patient have a confirmed intolerance or inadequate response to a trial with at least one preventive medication from two of the following classes: beta blockers, antidepressants, anticonvulsants)?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of episodic cluster headaches?

☐ Yes ☐ No

Q4. Does the patient have a history of inadequate response, intolerance or contraindication to at least one other preventative medication recommended by current consensus guidelines for episodic cluster headache?

☐ Yes ☐ No

Q5. Additional Information:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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