

## MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Spritam - Step Therapy - 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.

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:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility n	ame (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box and sign he life or health of the enrollee or the enrollee's ability to regain max		2 hour standard review timeframe may seriously jeopardize
Drug Name: Strength:		
Directions / SIG:		
Please attach any pertinent medical history incl Please answ	uding labs and information fo er the following questions an	
Q1. Has the patient tried formulary leveti	racetam 100 mg/ml solu	ition?
□Yes	□ No	
Q2. Requested Duration:		
☐ 12 Months	☐ Other:	
Q3. Additional Information:		
Prescriber Signature		Date
		v2025

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