Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Synarel

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. What is the patient's diagnosis?

- ☐ Central precocious puberty (CPP) - For initial, go to 2. For renewal, go to 8.
- ☐ Endometriosis
- ☐ Uterine leiomyomata (fibroids) - Go to 6..
- ☐ Prevention of recurrent menstrual related attacks in acute porphyria - Go to 7.

Q2. Has intracranial tumor been evaluated by appropriate lab tests and diagnostic imaging, such as computed tomography (CT scan), magnetic resonance imaging (MRI), or ultrasound?

☐ Yes ☐ No

Q3. Has the diagnosis of CPP been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay? Please attach documentation.

☐ Yes ☐ No

Q4. Does assessment of bone age versus chronological age support the diagnosis of CPP?

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☐ Yes ☐ No

Q5. Was the patient less than 8 years of age for females or less than 9 years of age for males at the onset of secondary sexual characteristics?

☐ Yes ☐ No

Q6. Does the patient meet ONE of the following criteria:
A) The patient has anemia due to uterine leiomyomata.
B) The requested medication will be used prior to surgery for uterine leiomyomata?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with a physician experienced in the management of porphyrias?

☐ Yes ☐ No

Q8. Is the patient currently less than 12 years of age if female and 13 years of age if male?

☐ Yes ☐ No

Q9. Is the patient currently receiving the requested medication?

☐ Yes ☐ No

Q10. Is the patient experiencing treatment failure such as clinical pubertal progression, lack of growth deceleration, and continued excessive bone age advancement?

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature _____ Date _____

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