Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Teriflunomide

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. Is this an initial request?

☐ Yes - Go to 3 ☐ No - Go to 2

Q2. Has the patient experienced disease stability or improvement while receiving teriflunomide?

☐ Yes ☐ No

Q3. Has the patient been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)?

☐ Yes ☐ No

Q4. Has the patient been diagnosed with clinically isolated syndrome of multiple sclerosis?

☐ Yes ☐ No

Q5. Will the patient be using teriflunomide concomitantly with other disease modifying multiple sclerosis agents? Note: Ampyra and Nuedexta are not disease modifying.

Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Teriflunomide

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:**

☐ Yes	☐ No
Q6. Is the patient 18 years of age or older?	
☐ Yes	☐ No
Q7. Do the benefits of taking teriflunomide outweigh the risks?	
☐ Yes	☐ No
Q8. Additional Information:	

Prescriber Signature

Date

2024 Prior Authorization Request