Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Acute Seizure Agents

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 the patient within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q2. Is the medication being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q3. Does the patient have acute narrow-angle glaucoma?

☐ Yes ☐ No

Q4. Is there documentation showing that the medication is being used for a medically accepted indication?

☐ Yes ☐ No

Q5. Does the patient have a documented history of inadequate response, intolerance or contraindication to formulary acute seizure agents?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Additional Information:

Prescriber Signature

Date

v2026

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