Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Strensiq - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

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.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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 a request for continuation of therapy? If YES, go to 8. If NO, go to 2.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

☐ Yes ☐ No

Q3. Did the onset of disease occur prior to age of 18 years?

☐ Yes ☐ No

Q4. Are there clinical signs and symptoms of hypophosphatasia, applicable labs and/or tests provided supporting the diagnosis? Examples include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, vitamin B6-dependent seizures, failure to thrive, delayed walking, waddling gait, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

☐ Yes ☐ No

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Q5. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?

☐ Yes ☐ No

Q6. Has the patient been appropriately evaluated and confirmation the patient does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?

☐ Yes ☐ No

Q7. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?

☐ Yes ☐ No

Q8. Has documentation of clinical benefit been provided, as shown by improvement in any of the following: clinical symptoms, radiographic findings, respiratory assessments, pulmonary function testing, growth parameters, mobility, pain assessments?

☐ Yes ☐ No

Q9. Has documentation of ophthalmic and renal monitoring (concern for ophthalmic or renal ectopic calcifications) been provided?

☐ Yes ☐ No

Q10. Is the requested dose within the FDA labeled dosing guidelines (patient's weight must be provided)?

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

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