Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Brand Major Depressive Disorder Agents

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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. Does the patient have a documented diagnosis of Major Depressive Disorder?

☐ Yes ☐ No

Q2. Is the request for Raldesy?

☐ Yes ☐ No

Q3. Is there documentation showing inability to or difficulty with swallowing solid dosage forms?

☐ Yes ☐ No

Q4. Is there documentation of inadequate response, intolerance, or contraindication to two of the following: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclics?

☐ Yes ☐ No

Q5. Is the request for Auvelity?

☐ Yes ☐ No

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Brand Major Depressive Disorder Agents

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.

Member Name:	**Prescriber Name:**

Q6. Are chart notes attached documenting a diagnosis of agitation associated with dementia due to Alzheimer's disease?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 months ☐ Other

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2026