Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Albendazole

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 requested drug being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. Has the infection has been confirmed by a diagnostic or laboratory test (e.g., imaging scans, scotch tape test, blood, stool, or urine test)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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