2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Actimmune - Medicare

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.

Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:	Office Contact:	
Line of Business: Medicare		NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:			Specialty/facility name (if applicable):	
	<u>DITED REVIEW</u> : By checking this box and signi nrollee or the enrollee's ability to regain maxi		hour standard review timeframe may seriously jeopardize	
Drug Name:				
Strength:				
Directions / SIG:				
Q1. Is the received	uested medication being us	er the following questions and ed for a medically acce	oted indication not otherwise	
☐ Yes		□No		
Q2. Has documentation of the diagnosis been provided?				
☐ Yes		☐ No	□ No	
Q3. Requeste	ed Duration:			
☐ 12 Months		☐ Other		
Q4. Additiona	ll Information:			
Prescriber Signature			Date 2024 Medicare Prior Authorization Request	
			2024 Medicare Prior Authorization Request	

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