2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



High Risk Meds - General - Medicare

Fax back to: 866-371-3239 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.

Patient Name:	Prescriber Name:	Prescriber Name:	
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Line of Business: □ Medicare	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nar	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box the life or health of the enrollee or the enrollee's ability to reg		hour standard review timeframe may seriously jeopardize	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical histo	ry including labs and information for answer the following questions and		
Q1. Is the patient 65 years of age or to patients 65 years of age or older. of age.]	-		
Q2. Is this High Risk Medication bei indication for use and the patient's c	ng used for a medically accep	ted indication? Please list	
☐ Yes	□ No		
Q3. What is the patient's diagnosis?			
Q4. Has a risk-versus-benefit asses	sment been completed for the	High Risk Medication?	
☐ Yes	☐ No		
Q5. Has the patient been counseled Risk Medication?	on the potential side effects a	and risks of the requested High	
☐ Yes	□No		
Q6. Does the benefit outweigh the p	ootential risk?		

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

* * * * * * * * * * * * * * * * * * * *	. 6. ,	•
Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Q7. Requested Duration:		
☐ 12 months	☐ Other	
Q8. Additional Information:		
Prescriber Signature	Dat	e or Authorization Request
	2024 Medicare Pric	ir Authorization Reduest