2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Lucemyra - 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.

Patient Name:	Prescriber Name:		
Member Number:	Fax: Phone:		
Date of Birth:	Office Contact:		
Line of Business:	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 the life or health of the enrollee or the enrollee's ability t	box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize o regain maximum function.		
Drug Name:			
Strength:			
Directions / SIG:			
Diagram of the character of the characte			
• •	story including labs and information for this member that may support approval. ase answer the following questions and sign.		
Q1. Is the patient 18 years of age			
Yes	□ No		
103			
Q2. Does the patient have a diagnosis of acute opioid withdrawal documented by an opioid withdrawal scale (such as Objective Opioid Withdrawal Scale [OOWS], Clinical Opioid Withdrawal Scale [COWS], Subjective Opioid Withdrawal Scale [SOWS])? Chart notes must be attached			
☐ Yes	□ No		
Q3. Does the patient have documentation of an inadequate response, inability to tolera contraindication to clonidine?			
☐ Yes	□ No		
Q4. Requested Duration:			
☐ 14 Days	☐ Other:		
Q5. Additional Information:			
Prescriber Signature			

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Lucemyra - 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:	_
ratient name.	Flescriber Name.	

2024 Medicare Prior Authorization Request