2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Oxervate - 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:	
Member Number:		-ax:	Phone:
Date of Birth:		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):	
REQUEST FOR EXPEDITED REVIEW: By che the life or health of the enrollee or the enrolle			ndard review timeframe may seriously jeopardize
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent m	edical history including labs	and information for this m	ember that may support approval.
	Please answer the follo	wing questions and sign.	
Q1. Is the prescriber a oph	ıthalmologist?		
☐ Yes		□No	
Q2. Is there documentation indication not otherwise ex	<u> </u>	cation is being used	for a medically accepted
□ Yes		□No	
Q3. Requested duration:			
☐ 8 weeks		☐ Other	
Q4. Additional Information	:		
Prescriber Signature			Date
		2024 N	Medicare Prior Authorization Request

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