2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Panretin - 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: | | |
| 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 checking this the life or health of the enrollee or the enrollee's ability Drug Name: | s box and signing below, I certify that applying the 72 hour s to regain maximum function. | standard review timeframe may seriously jeopardize | |
| Strength: | | | |
| Directions / SIG: | | | |
| Q1. Is the requested medication | ease answer the following questions and signal being used for a medically accepted rovide documentation of diagnosis. | | |
| · | · · | | |
| Yes | □ No | | |
| Q2. Is the requested medication | being prescribed by a dermatologist | or oncologist? | |
| ☐ Yes | □ No | | |
| Q3. Requested Duration: | | | |
| ☐ 12 months | ☐ Other: | | |
| Q4. Additional Information: | | | |
| Prescriber Signature | 202/ | Date | |

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