2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Topical Retinoids - 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.

	B
Patient 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):
he life or health of the enrollee or the enrollee's ability to regain maximum functi	certify that applying the 72 hour standard review timeframe may seriously jeopardize on.
Drug Name:	
Strength: Directions / SIG:	
Directions / Sig.	
Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.	
Q1. Is the requested medication being used for a excluded from Part D? Please provide documen	
□Yes	□ No
Q2. Requested Duration:	
☐ 12 Months	☐ Other:
Q3. Additional Information:	
Prescriber Signature	Date
	2024 Medicare Prior Authorization Request

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