

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Brimonidine Topical Gel

Fax back to: (833) 605-4407 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.

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:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
Drug Name: Strength: Directions / SIG:	and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of tion.
Please	ory including labs and information for this member that may support approval. e answer the following questions and sign.
Q1. Does the patient have documer rosacea?	nted diagnosis of persistent (non-transient) erythema of
☐ Yes	□ No
Q2. Is the patient 18 years of age o	r older?
☐ Yes	□ No
Q3. Additional Information:	
Prescriber Signature	Date
	2024 Prior Authorization Request

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