

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Jublia

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):

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
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 drug being prescribed for onychomycosis of the toenail(s) due to trichophyton rubrum or trichophyton mentagrophytes?		
□ Yes	□ No	
Q2. Has the patient's diagnosis been confirmed with a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?		
□ Yes	□ No	
Q3. Has the patient experienced an inadequate treatment response to an oral antifungal therapy (e.g., terbinafine, itraconazole)?		
□ Yes	□ No	
Q4. Has the patient experienced an intolerance to an oral antifungal therapy (e.g., terbinafine, itraconazole)?		
□ Yes	□ No	

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 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Jublia

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.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached will delay the review process.		
Patient Name:	Prescriber Name:	
Q5. Does the patient have a contraindication that would prohibit a trial of an oral antifungal therapy (e.g., terbinafine, itraconazole)?		
□ Yes	□ No	
Q6. Is the requested drug being used in a footbath?		
□ Yes	□ No	
Q7. Additional Information:		

Prescriber Signature

Date

2024 Prior Authorization Request

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