

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Oral Oncology Agents**

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):
the enrollee or the enrollee's ability to regain maximum f	oox and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of unction.
-	
Strength:  Directions / SIG:	
Directions / Sig.	
	story including labs and information for this member that may support approval.
Q1. Is the requested medication Please provide documentation of	peing used for a FDA-approved medically accepted indication? diagnosis.
☐ Yes	□ No
Q2. Additional Information:	
Prescriber Signature	Date
	2024 Prior Authorization Request

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