

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Phenoxybenzamine

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 att	tached WILL delay the review process.	
Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax: Phone:	Fax: Phone:	
Date of Birth:		Office Contact:	Office Contact:	
Line of Business: □ E	xchange - PA	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility name (if a	Specialty/facility name (if applicable):	
	<u>PREVIEW</u> : By checking this box and signing ability to regain maximum function.	below, I certify that the standard review timef	rame may seriously jeopardize the life or health o	
Drug Name:				
Strength: Directions / SIG:				
Directions / Oro.				
Please attach any	· ·	ling labs and information for this me the following questions and sign.	ember that may support approval.	
	sted drug being prescribed o control episodes of hype	d for the treatment of pheochertension and sweating?	romocytoma or	
☐ Yes		□ No		
	sted drug being prescribed or endocrine surgeon?	by or in consultation with a	nephrologist,	
☐ Yes		□No		
	•	ponse, intolerance or contrai doxazosin, prazosin, terazo		
□Yes		□ No		
Q4. Additional Ir	formation:			
Prescriber Signature				

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2024 Prior Authorization Request