

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Step Therapy Exception 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 (nation) 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 the enrollee or the enrollee's ability to regain maximum	s box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of function.
Drug Name:	
Strength:	
Directions / SIG:	
	nistory including labs and information for this member that may support approval. ease answer the following questions and sign.
	for an FDA-approved or nationally recognized compendia se supported by peer-reviewed medical literature (not including light loss).?
☐ Yes	□ No
Q2. Has the patient had an inade alternative drugs per step therap	equate response, inability to tolerate, or is unable to use the by criteria?
☐ Yes	□ No
Q3. Additional Information:	
Prescriber Signature	Date 2024 Prior Authorization Request

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