Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Isotretinoins

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. Does the patient have any of the following diagnoses: A) severe recalcitrant nodular acne vulgaris, B) refractory acne vulgaris, C) severe refractory rosacea?

☐ Yes ☐ No

Q2. Has the patient tried and had an inadequate treatment response to any topical acne product AND an oral antibiotic?

☐ Yes ☐ No

Q3. Will treatment be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course?

☐ Yes ☐ No

Q4. Does the patient have any of the following diagnoses: A) neuroblastoma, B) cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), C) is at high risk for developing skin cancer (squamous cell cancers), D) transient acantholytic dermatosis (Grover's Disease), E) keratosis follicularis (Darier Disease), F) lamellar ichthyosis, G) pityriasis rubra pilaris?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request