

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Actimmune - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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

PLEASE NOTE: Any information (patient, pres	scriber, drug, labs) leπ blank, illegible, or no	ot attached WILL delay the review process.	
Member Name:	Prescriber Name:	Prescriber Name:	
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Line of Business:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box an he life or health of the enrollee or the enrollee's ability to regain Drug Name: Strength:		standard review timeframe may seriously jeopardize	
Directions / SIG:			
Please attach any pertinent medical history Please a	including labs and information for this enswer the following questions and sig		
Q1. Is the requested medication being excluded from Part D?	g used for a medically accepted	d indication not otherwise	
☐ Yes	□ No		
Q2. Has documentation of the diagno	osis been provided?		
☐ Yes	□ No		
Q3. Requested Duration:			
☐ 12 Months	☐ Other		
Q4. Additional Information:			
Prescriber Signature		Date	
		v2025	

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