

## MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Bronchitol - 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 review process.			
Member Name:	Prescriber Name:		
Member Number:	Fax: Phone:		
Date of Birth:	Office Contact:		
Line of Business:   Medicare Advantage	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 do the life or health of the enrollee or the enrollee's ability to regain maximum function.	certify that applying the 72 hour standard review timeframe may seriously jeopardize on.		
Drug Name:			
Strength: Directions / SIG:			
	s and information for this member that may support approval. owing questions and sign.		
Q1. Is this a reauthorization request?			
□Yes	□ No		
Q2. If renewal, is there confirmation of improvem	nent in condition?		
□Yes	□ No		
Q3. Is the request for an FDA-approved indication diagnosis.	on? Please provide documentation of		
□Yes	□ No		
Q4. Is there confirmation that the member has pa	assed a Bronchitol Tolerance Test?		
□Yes	□ No		
Q5. Is there confirmation that Bronchitol will be u bronchodilators, inhaled antibiotics) to improve p	, , , , ,		
□Yes	□ No		

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Member Name:	Prescriber Name:		
Q6. Requested Duration:			
☐ 12 months	☐ Other		
Prescriber Signature		Date	v2025