2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Livalo - Step Therapy - 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,

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Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:		
Line of Business: Medicare		NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:			Specialty/facility name (if applicable):	
	DITED REVIEW: By checking this box and sign rollee or the enrollee's ability to regain many.		'2 hour standard review timeframe may seriously jeopardize	
Drug Name:				
Strength:				
Directions / SIG:				
Please attach	•	cluding labs and information for the following questions are	or this member that may support approval.	
Q1. Has the part A) atorvastatin, B) lovastatin, C) pravastatin D) rosuvastatin E) simvastatin F) ezetimibe/	n, tin, n,	of the following: □ No		
		INO		
Q2. Duration:	· •			
☐ 12 months		☐ Other		
Q3. Additiona	al Information:			
	Prescriber Signature		Date	
			2024 Medicare Prior Authorization Request	

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