

## 2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Inhalation Sol-Tobramycin - 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.

| Patient Name:   |  | Prescriber Name:              | Prescriber Name:                                   |  |
|---|--|-------------------------------|--|--|
| Member Number:  |  | Fax:                          | Phone:   |  |
| Date of Birth:  |  | Office Contact:               | Office Contact:                                    |  |
| Line of Business: □ Medicare                                  |  | NPI:                          | State Lic ID:                                      |  |
| Address:  |  | Address:                      | Address:   |  |
| City, State ZIP:  |  | City, State ZIP:              | City, State ZIP:                                   |  |
| Primary Phone:  |  | •                             | Specialty/facility name (if applicable):           |  |
|   | <u>DITED REVIEW</u> : By checking this box and signing belon incollee or the enrollee's ability to regain maximum for |                               | standard review timeframe may seriously jeopardize |  |
| Drug Name:  |  |                               |  |  |
| Strength:   |  |                               |  |  |
| Directions / SIG:   |  |                               |  |  |
| Please attach   | any pertinent medical history including  | labs and information for this | s member that may support approval.                |  |
|   | Please answer the  | following questions and sig   | n.   |  |
| Q1. Is the patient using the requested drug with a nebulizer? |  |                               |  |  |
| ☐ Yes   |  | ☐ No                          | □ No   |  |
|   | patient have a diagnosis of cys<br>, J47.0, J47.1, J47.9, Q33.4)?  | tic fibrosis or bronchiec     | tasis (ICD-10 diagnosis codes                      |  |
| ☐ Yes   |  | □ No                          | □ No   |  |
| Q3. Requeste  | ed Duration:   |                               |  |  |
| ☐ 12 Months   |  | ☐ Other:                      |  |  |
| Q4. Additional Information:                                   |  |                               |  |  |
|   |  |                               |  |  |
| Prescriber Signature  |  |                               | Date   |  |
|   |  | 202                           | 4 Medicare Prior Authorization Request             |  |

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