



Part B vs D: Injectables - 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:	
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:	
Primary Phone:	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, the life or health of the enrollee or the enrollee's ability to regain maximum func		ur standard review timeframe may seriously jeopardize
Drug Name: Strength:		
Directions / SIG:		
Please attach any pertinent medical history including later than Please answer the formal Q1. Is the requested drug being supplied from the properties of th	llowing questions and s	ign.
as part of a physician service (i.e., the drug is be		
□Yes	□ No	
Q2. Requested Duration:		
☐ 12 Months	☐ Other:	
Q3. Additional Information:		
Prescriber Signature	24	Date
	20)24 Medicare Prior Authorization Request

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