



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Phenoxybenzamine

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug being prescribed for the treatment of pheochromocytoma or paraganglioma to control episodes of hypertension and sweating?

Yes checkbox

No checkbox

Q2. Is the requested drug being prescribed by or in consultation with a nephrologist, endocrinologist, or endocrine surgeon?

Yes checkbox

No checkbox

Q3. Has the patient had an inadequate response, intolerance or contraindication to at least one selective adrenergic receptor blocker (e.g., doxazosin, prazosin, terazosin)?

Yes checkbox

No checkbox

Q4. Additional Information:

Prescriber Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Phenoxybenzamine**

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

---

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.**

|                      |                         |
|----------------------|-------------------------|
| <b>Patient Name:</b> | <b>Prescriber Name:</b> |
|----------------------|-------------------------|

v2025