Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Member Reimbursement - 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, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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. Prescription number:

Q2. NDC number for the medication:

Q3. Is/are the medications formulary? If not, a coverage determination will have to be made.

☐ Yes ☐ No

Q4. Dates of fill:

Q5. Quantity filled:

Q6. Days Supply Filled:

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Patient Name:	**Prescriber Name:**

Q7. Pharmacy Name:

Q8. Pharmacy Address:

Q9. Pharmacy NABP:

Q10. Amount requested for reimbursement:

Q11. Is/are there receipts attached?

☐ Yes ☐ No

Q12. Are any of the medications being taken for an on-the-job injury?

☐ Yes ☐ No

Q13. Are any of the medications being taken related to an auto accident?

☐ Yes ☐ No

Q14. Is the medication covered under any other group insurance?

☐ Yes ☐ No

Q15. If Yes, is other coverage:

☐ Primary. Must attach the Explanation of Benefits (EOB). ☐ Secondary.

Q16. Was an out-of network pharmacy used?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q17. If yes, provide the reason:

☐ Travel within the United States but outside of the Plan's service area

☐ Unable to get a covered drug in a timely manner.

☐ There was not a network pharmacy nearby that provided 24/7 service.

☐ Trying to fill a covered drug that is not regularly stocked at a network retail or mail order pharmacy (may include orphan drugs or specialty medications).

☐ Patient in an Emergency Department, Provider-based clinic, Outpatient surgery, or Other outpatient setting.

☐ Other (please provide reason)

Q18. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request