

## MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Oral Oncology Agents - 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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Member Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
Drug Name: Strength: Directions / SIG:	ain maximum function.
Directions / Sig:	
	y including labs and information for this member that may support approval. answer the following questions and sign.
Q1. Is the requested medication bei excluded from Part D? Please provi	ng used for a medically accepted indication not otherwise de documentation of diagnosis.
☐ Yes	□ No
Q2. Requested Duration:	
☐ 12 Months	☐ Other
Q3. Additional Information:	
Prescriber Signature	Date
	v202

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