

## MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Topical Retinoids - 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):	
he life or health of the enrollee or the enrollee's ability to rega  Drug Name:  Strength:	d signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardiz n maximum function.	
Directions / SIG:		
	including labs and information for this member that may support approval.	_
Q1. Is the requested medication bein excluded from Part D? Please provide	g used for a medically-accepted indication not otherwise e documentation of diagnosis.	
☐ Yes	□ No	
Q2. Requested Duration:		
☐ 12 Months	☐ Other:	
Q3. Additional Information:		
		_
Prescriber Signature	Date	
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