

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Voriconazole - 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 reg Drug Name: Strength:	and signing below, I certify that applying the 72 hour standard review timeframe may seriously j ain maximum function.	
Directions / SIG:		
Please	ry including labs and information for this member that may support approanswer the following questions and sign.	oval.
Part D? Please provide documentat	an FDA-approved indication not otherwise excluded from on of diagnosis.	
☐Yes	□ No	
Q2. Requested Duration:		
☐ 6 Months	☐ Other	
Q3. Additional Information:		
Prescriber Signature	 Date	
		v2025

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