

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Lidocaine Patches - 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: <input type="checkbox"/> 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.

<p>Q1. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a known history of sensitivity to local anesthetics of the amide type, or to any other component of this product?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have a documented diagnosis of pain associated with post-herpetic neuralgia or diabetic peripheral neuralgia? Chart notes must be attached.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Additional Information:</p>
<p>Q5. Requested Duration:</p> <p><input type="checkbox"/> 12 Months <input type="checkbox"/> Other</p>

Prescriber Signature

Date

2024 Medicare Prior Authorization Request

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



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Lidocaine Patches - 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:
----------------------	-------------------------