

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Besremi - 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.

Patient Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	1 1101101
Line of Business: Medicare	NPI:	State Lic ID:
		State Lit ID.
Address:	Address:	
City, State ZIP: Primary Phone:	City, State ZIP: Specialty/facility name	o (if applicable):
REQUEST FOR EXPEDITED REVIEW: By the life or health of the enrollee or the enro	y checking this box and signing below, I certify that applying the 72 hou ollee's ability to regain maximum function.	ur standard review timeframe may seriously jeopardize
Strength:		
Directions / SIG:		
Q1. Does the patient hav	Please answer the following questions and si	ign.
□Yes	□No	
Q2. Is the medication be	eing prescribed by or in consultation with a	hematologist or oncologist?
☐ Yes	□ No	
Q3. Is documentation att to hydroxyurea?	tached showing inadequate response, intol	erance to, or contraindication
☐ Yes	□ No	
Q4. Duration:		
☐ 12 months	☐ Other	
Q5. Additional Information	on:	

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
	2024 Medicare Prior Authorization Request	