



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tobramycin inhalation

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable)

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: 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.

Q1. Is the patient 2 years of age or older with cystic fibrosis?

Yes No

Q2. Does the patient have non-cystic fibrosis bronchiectasis?

Yes No

Q3. Does the patient have one of the following:

- A) Pseudomonas aeruginosa is present in airway cultures
B) The member has a history of Pseudomonas aeruginosa infection or colonization in the airways?

Yes No

Q4. Additional Information:

Yes No



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
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Prescriber Signature

Date

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