

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Cayston

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 NO	TE: Any information (patient, prescriber, drug,	labs) left blank, illegible, or	not attached WILL delay the review process.	
Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax: Phone:		
Date of Birth:		Office Contact:		
Line of Business:	□ Exchange - PA	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:		Specialty/facility nam	ne (if applicable):	
he enrollee or the enrol	DITED REVIEW: By checking this box and signing below lee's ability to regain maximum function.	, I certify that the standard revie	ew timeframe may seriously jeopardize the life or health of	
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. Does the patient have documentation of a diagnosis of cystic fibrosis (CF)?				
☐ Yes		□No		
	edication being prescribed by or in tes in the treatment of cystic fibros			
☐Yes		□ No		
	patient have a lung infection with with documentation attached)?	airway cultures pos	sitive for Pseudomonas	
☐ Yes		□No		
Q4. Additiona	al Information:			
	Prescriber Signature		Date	

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