



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Part D Insulin Syringes - 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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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><b>Q1. Is documentation attached showing that the member is diagnosed with diabetes mellitus?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q2. Is there documentation showing the patient will be using the requested product for the purpose of delivering insulin to the body? Please include medical records if the patient is using insulin with an insulin pump.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q3. Requested Duration:</b></p> <p><input type="checkbox"/> 12 Months <input type="checkbox"/> Other:</p>
<p><b>Q4. Additional Information:</b></p>

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Prescriber Signature Date