Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Exception - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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.

Q1. Is the requested medication being prescribed for a medically accepted indication not otherwise excluded from Part D? Please provide diagnosis

☐ Yes ☐ No

Q2. For high-risk medications in patients over the age of 65: is there documentation showing that the benefits of treatment with the requested drug outweigh the potential risks?

☐ Yes ☐ No

Q3. Is the patient stable on the current medication and is there a high risk of significant adverse clinical outcome with a medication change? [Note: Please specify anticipated significant adverse clinical outcome.]

☐ Yes ☐ No

Q4. Is this a request for a non-formulary medication?

☐ Yes ☐ No

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Q5. Has the patient tried and failed, had an adverse outcome, or has a contraindication to all formulary alternatives? [Note: Please specify the drug(s) contraindicated or tried, adverse outcomes for each, and if a therapeutic failure, the length of therapy for each drug.]

☐ Yes ☐ No

Q6. Is this a request for a medication at a higher dosage than allowed by the plan?

☐ Yes ☐ No

Q7. Has the patient tried and failed the medication at a lower dosage and this dosage was not appropriate? [Note: Please specify the following: the outcome of the trial, the medical reason for higher dosage, why less frequent dosing with a higher strength would not be an option for the patient (if higher strength exists).]

☐ Yes ☐ No

Q8. Is this a request for a medication in which the dosage form is non-formulary?

☐ Yes ☐ No

Q9. Has the patient tried and failed the formulary dosage form? [Note: Please specify the dosage form tried, the result of the trial, and the medical reason why the non-formulary dosage form is necessary.]

☐ Yes ☐ No

Q10. Is this a request for a medication that interacts with or is a duplication of therapy with another medication that the patient is currently taking?

☐ Yes ☐ No

Q11. Will the interacting or duplicative medication be discontinued?

☐ Yes ☐ No

Q12. Is there documentation to show that the patient will be monitored while taking the interacting or duplicative medications?

☐ Yes ☐ No

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Q13. Is this a request for an early refill of a medication?

☐ Yes ☐ No

Q14. Has an early refill request for the same medication been made within the last 90 days?

☐ Yes ☐ No

Q15. Will the patient be temporarily absent from the Commonwealth or the United States for an extended period of time that is greater than the remaining day supply of the earlier-dispensed medication?

☐ Yes ☐ No

Q16. Is this a request for a change in dosage of the medication or increased dosing frequency?

☐ Yes ☐ No

Q17. Was the medication lost or stolen?

☐ Yes ☐ No

Q18. Has documentation (such as a copy of a police report and full description of events with date and time of theft or loss, an insurance report, fire report, etc.) of the loss or theft been provided?

☐ Yes ☐ No

Q19. Requested Duration:

☐ 12 months ☐ Other:

Q20. Additional Information:

Prescriber Signature

Date

v2026

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