

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Regranex

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

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Member Name:	Prescriber Name:		
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Line of Business:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility r	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this bo he life or health of the enrollee or the enrollee's ability to reduce the enrollee		2 hour standard review timeframe may seriously jeopardize	
	ory including labs and information for answer the following questions are	or this member that may support approval.	
Q1. Will this medication be used fo Chart notes must be attached.	r the treatment of lower extre	mity diabetic neuropathic ulcers?	
□Yes	□ No		
Q2. Is the patient greater than or equal to 16 years of age?			
☐ Yes	□ No		
Q3. Requested Duration:			
☐ 5 months	☐ Other		
Q4. Additional Information:			
Prescriber Signature		Date v2026	

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