

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Topical Retinoids - 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:	i none.
Line of Business: Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box a he life or health of the enrollee or the enrollee's ability to reg Drug Name: Strength:		ur standard review timeframe may seriously jeopardize
Directions / SIG:		
Please attach any pertinent medical histor	ry including labs and information for the answer the following questions and s	
Q1. Is the requested medication bei excluded from Part D? Please provide		
☐Yes	□No	
Q2. Requested Duration:		
☐ 12 Months	☐ Other:	
Q3. Additional Information:		
Prescriber Signature		Date
		v2026

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