



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Bexarotene
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 NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and 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 patient equal to or greater than 18 years of age?

Yes No

Q2. Is the medication being prescribed by or in consultation with an oncologist or dermatologist?

Yes No

Q3. Is this prescribed for the treatment of an FDA approved indication?

Yes No

Q4. Does the patient have an intolerance, contraindication or therapeutic failure to one prior treatment: such as surgical excision, radiation, phototherapy, topical corticosteroids, topical imiquimod, systemic or topical chemotherapy (mechlorethamine [nitrogen mustard], carmustine)?

Yes No

Q5. Is the patient a female?



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Form with fields for Patient Name, Prescriber Name, and questions Q6 through Q10 regarding pregnancy tests, previous approvals, and patient demographics.

Prescriber Signature

Date

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