

MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Febuxostat - Step Therapy - 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.

		<u> </u>
Patient Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nam	e (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing the life or health of the enrollee or the enrollee's ability to regain maximu Drug Name: Strength: Directions / SIG:		ur standard review timeframe may seriously jeopardize
Please attach any pertinent medical history includi Please answer t	ng labs and information for the following questions and s	
Q1. Has the patient tried allopurinol?		
□Yes	□No	
Q2. Requested Duration:		
☐ 12 months	☐ Other	
Q3. Additional Information:		
Prescriber Signature		Date
		v2025

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