Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Chorionic Gonadatropin (hCG)

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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. What is the diagnosis?

☐ Hypogonadotropic hypogonadism ☐ Prepubertal cryptorchidism

Q2. For hypogonadotropic hypogonadism, does the patient meet both of the following criteria? Labs must be attached.
a. Low pretreatment testosterone levels
b. Low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels

☐ Yes ☐ No

Q3. For prepubertal cryptorchidism, is there documentation attached confirming diagnosis?

☐ Yes ☐ No

Q4. Additional Information:

_____ _____

Prescriber Signature Date

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