Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Pegasys (peginterferon alfa 2a)

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. Is the member prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Does the member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q3. Does the member have the diagnosis of HBV?

☐ Yes ☐ No

Q4. Does the member have documented results of the following? a. Hepatitis B surface antigen (HBsAg); b. HBV DNA; c. Complete blood count (CBC); d. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels).

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Additional Information:

Prescriber Signature

Date

v2025