Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Alpha-1 Proteinase Inhibitors

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 18 years of age or older?

☐ Yes ☐ No

Q2. Does the member have a diagnosis of emphysema due to severe congenital deficiency of Alpha1-P1?

☐ Yes ☐ No

Q3. Has the drug been prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q4. Does the member have Immunoglobulin A (IgA) deficiency with known antibodies to IgA?

☐ Yes ☐ No

Q5. Has, included with the request, documentation of testing that confirms one of the following homozygous protein phenotypes: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) AND labs that show baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 micromol/L as documented

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by either of the following: less than 57mg/dL as determined by nephelometry OR less than 80mg/dL as determined by radial immunodiffusion)?

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request