Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Pulmozyme

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 Pulmozyme being prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of cystic fibrosis? (Please attach documentation of diagnosis).

☐ Yes ☐ No

Q3. Is Pulmozyme being prescribed in conjunction with standard therapies (such as CFTR [cystic fibrosis transmembrane conductance regulator] modulators, oral, inhaled and/or parenteral antibiotics, bronchodilators, pancreatic enzyme supplements, vitamins, oral or inhaled corticosteroids, inhaled hypertonic saline, analgesics, and chest physiotherapy) for cystic fibrosis?

☐ Yes ☐ No

Q4. Is Pulmozyme being prescribed at a dose of 2.5 mg once daily?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is Pulmozyme being prescribed at a dose of 2.5 mg twice daily?

☐ Yes ☐ No

Q6. Has documentation of an adequate trial of once daily dosing consisting of at least a 2-week trial been submitted? (Please attach documentation of previous trial).

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request