Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Alvaiz - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 this a request for reauthorization and the patient had a positive clinical response and remains at risk for bleeding complications?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of thrombocytopenia in a patient with chronic immune thrombocytopenia (ITP)?

☐ Yes ☐ No

Q3. Is documentation included that baseline platelet count is less than 30,000/mcL?

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response, intolerance, or contraindication to glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy?

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☐ Yes ☐ No

Q6. Does the patient have a diagnosis of thrombocytopenia in a patient with chronic hepatitis C?

☐ Yes ☐ No

Q7. Has the patient's degree of thrombocytopenia (e.g. less than 75,000/mcL) prevented the initiation of interferon-based therapy or limited the ability to maintain interferon-based therapy?

☐ Yes ☐ No

Q8. Does the patient have the diagnosis of severe aplastic anemia?

☐ Yes ☐ No

Q9. Is documentation included that baseline platelet count is less than 30,000/mcL?

☐ Yes ☐ No

Q10. Has the patient had an inadequate response, intolerance, or contraindication to immunosuppressive therapy?

☐ Yes ☐ No

Q11. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q12. For ITP and severe aplastic anemia: Is Alvaiz being prescribed by or in consultation with a hematologist? OR for thrombocytopenia in patients with chronic hepatitis C: Is Alvaiz being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q13. Requested Duration:

☐ 12 Months ☐ Other

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Member Name:	**Prescriber Name:**

Q14. Additional Information:

_____ _____

Prescriber Signature Date

v2025

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