



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Filgrastim Agents

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, 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.

Form with fields: 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 medication being used a medically accepted indication not otherwise excluded from Part D?

Yes

No

Q2. Are chart notes or documentation provided to support that the medication is being used for a specified medically accepted indication not otherwise excluded from Part D?

Yes

No

Q3. Are chart notes provided that show lab work (CBC with differential including ANC) is being monitored prior to initiation of the medication based on recommendations for that specific diagnosis?

Yes

No

Q4. Will chart notes be provided that show that lab work (CBC with differential, ANC) is being monitored during therapy based on recommendations for that specific diagnosis?

Yes

No



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| | |
|----------------------|-------------------------|
| Patient Name: | Prescriber Name: |
|----------------------|-------------------------|

Q5. Additional Information:

Prescriber Signature

Date
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