# Jefferson Health Plans

#### 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Ofev

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.

	Burnarilla Managaria	adiay inc review precess.	
Patient Name:	Prescriber Name:		
Member Number:	Fax: Phone:		
Date of Birth:	Office Contact:		
Line of Business: □ Exchange - PA	NPI: St	ate Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):		
REQUEST FOR EXPEDITED REVIEW: By checking the enrollee or the enrollee's ability to regain maximu	his box and signing below, I certify that the standard review timeframe may seri m function.	iously jeopardize the life or health of	
Drug Name:			
Strength:			
Directions / SIG:			
	history including labs and information for this member that Please answer the following questions and sign.	may support approval.	
Q1. Does the patient have the	diagnosis of idiopathic pulmonary fibrosis?		
☐ Yes	□ No		
	owing that the drug will be used to slow the rate ow with a diagnosis of systemic sclerosis-associated		
☐ Yes	□ No		
Q3. Does the patient have a dia progressive phenotype?	agnosis of chronic fibrosing interstitial lung diseas	se (ILD) with a	
☐ Yes	□ No		
Q4. Is Ofev being prescribed by	y, or in consultation with, a pulmonologist?		
☐ Yes	□ No		
Q5. Additional Information:			

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
	2024 Prior Authorization Request	