

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Pegfilgrastim Agents - 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.

Patient Name:	, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review proces Prescriber Name:	SS. ———
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business: Medicare	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 be the life or health of the enrollee or the enrollee's ability to	ox and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeop regain maximum function.	oardize
Drug Name:		
Strength:		
Directions / SIG:		
	story including labs and information for this member that may support approva ase answer the following questions and sign.	al.
Q1. Will pegfilgrastim be used as	primary prophylaxis against febrile neutropenia?	
☐ Yes	□ No	
Q2. Is the patient receiving myelo	suppressive chemotherapy (attach documentation)?	
☐ Yes	□ No	
Q3. Is the patient at increased risk	r for febrile neutropenia (attach documentation)?	
☐ Yes	□ No	
Q4. Is the patient receiving dose-	dense or high-dose chemotherapy (attach documentation)?	
☐ Yes	□ No	
Q5. Will pegfilgrastim be used as	secondary prophylaxis against febrile neutropenia?	
☐ Yes	□ No	
	suppressive chemotherapy with a history of febrile neutropenia otherapy for which primary prophylaxis was not received (attacl	

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Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Q7. For Ziextenzo Only: is there a diagnosis of hematopoietic subsyndrome of acute radiation syndrome with attached documentation of exposure to myelosuppressive doses of radiation?		
☐ Yes	□ No	
Q8. Will the patient's complete blood count with differential including absolute neutrophil count (ANC) be monitored?		
☐ Yes	□ No	
Q9. Is the medication being prescribed by a hematologist or oncologist?		
☐ Yes	□ No	
Q10. Requested Duration:		
☐ 12 Months	☐ Other:	
Q11. Additional Information:		
Prescriber Signature	Date	
	2024 Medicare Prior Authorization Request	