

## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Pegasys (peginterferon alfa 2a) 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, l	abs) left blank, illegible, or no	ot attached WILL delay the review process.	
Patient Name:		Prescriber Name:		
Member Number:		Fax: Phone:		
Date of Birth:		Office Contact:		
Line of Business:   Exch	ange - PA	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:		Specialty/facility name (if applicable):		
the enrollee or the enrollee's ability		I certify that the standard review	timeframe may seriously jeopardize the life or health of	
Drug Name:				
Strength: Directions / SIG:				
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 the member prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?				
□Yes		□No		
Q2. Does the member have a contraindication to the prescribed drug?				
☐ Yes		□No	□ No	
Q3. Does the member	per have the diagnosis of H	BV?		
☐ Yes		□No		
Q4. Does the member have documented results of the following? a. Hepatitis B surface antigen (HBsAg); b. HBV DNA; c. Complete blood count (CBC); d. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels).				
☐ Yes		□ No		

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Pegasys (peginterferon alfa 2a) 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:			
Q5. Additional Information:				
Prescriber Signature	Date			

v2025