Jefferson Health Plans

***2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM***

Part B vs D: Hepatitis B Vaccine - 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.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| 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 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 the patient at high or intermediate risk of contracting hepatitis B?
- High risk groups currently identified include but are not limited to:
Individuals with ESRD (End Stage Renal Disease)
Individuals with hemophilia who received Factor VIII or IX concentrates
Clients of institutions for individuals with intellectual disabilities (IID)
Persons who live in the same household as a hepatitis B virus carrier
Homosexual men
Illicit injectable drug abusers
Persons diagnosed with diabetes mellitus
- Intermediate risk groups currently identified include but are not limited to:
Staff in institutions for the individuals with intellectual disabilities (IID)
Health care workers with frequent contact with blood or blood-derived body fluids during routine work

☐ Yes ☐ No

Q2. Requested Duration:

☐ 12 Months ☐ Other:

Q3. Additional Information:

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

Prescriber Signature

Date

2024 Medicare Prior Authorization Request