Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Part B vs D Drugs - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 request for Hepatitis B vaccine (Engerix-B; Recombivax HB)?

☐ Yes ☐ No

Q2. Is the patient at intermediate to high risk for contracting Hepatitis B virus? Please provide diagnosis and ICD-10 code(s).

☐ Yes ☐ No

Q3. Is the request for Parenteral Nutrition (TPN)? Please provide medication, diagnosis, ICD-10 code(s) and J-Code(s) if applicable.

☐ Yes ☐ No

Q4. Does the patient have a permanent dysfunction of the digestive tract? Defined as dysfunction lasting greater than 90 days.

☐ Yes ☐ No

Q5. Is the request for an injectable medication that is usually non-self-administered (i.e. intramuscular (IM) injections, infusible drugs, subcutaneous drugs not usually self-administered)? Must provide medication, diagnosis, ICD-10 code(s), and J-Code(s) if applicable.

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Member Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Is the requested medication being furnished by a physician, health center or clinic, hospital, critical access hospital outpatient department, ambulance, end stage renal disease facility, comprehensive out-patient rehabilitation facility, hospital outpatient department, or hospital outpatient prospective payment system?

☐ Yes ☐ No

Q7. Is the request for a medication that will be administered via external or implantable pump? Must provide medication, diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q8. Will the requested medication be administered in the patient's home setting, as defined by CMS?

☐ Yes ☐ No

Q9. Is the request for an oral chemotherapy agent that has an IV equivalent? Must provide medication, diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q10. Is the medication being used only as an anti-cancer agent?

☐ Yes ☐ No

Q11. Is the request for an oral anti-emetic treatment related to cancer treatment? Must provide medication, diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q12. Is the oral anti-emetic being used as full replacement for intravenous administration and is it being used within 48 hours of cancer treatment?

☐ Yes ☐ No

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Q13. Is the request for an immunosuppressant? Must provide medication, diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q14. Did the patient receive a transplant from a Medicare-approved facility and were they enrolled in Medicare Part A at the time? Must provide transplanted organ and date of transplant.

☐ Yes ☐ No

Q15. Is the request for intravenous immune globulin that will be administered in the home setting? Please provide diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q16. Does the member have a diagnosis of primary immunodeficiency, including congenital hypogammaglobulinemia, immunodeficiency with increased IgM, common variable immunodeficiency, Wiskott-Aldrich syndrome, and combined immunity deficiency?

☐ Yes ☐ No

Q17. Is the request for an Erythropoiesis-Stimulating Agent (ESA)? Must provide medication, diagnosis, ICD code(s), and J-Code(s) if applicable.

☐ Yes ☐ No

Q18. Is the member currently receiving renal dialysis services and is the medication being supplied by an End Stage Renal Disease (ESRD) facility contracted with Medicare? Renal dialysis services are all items and services used to furnish outpatient maintenance dialysis in the ESRD facility or in a patient's home.

☐ Yes ☐ No

Q19. Is the requested ESA being used for a medically accepted indication other than ESRD and will it be provided and administered incident to a physician's professional service?

☐ Yes ☐ No

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Q20. Is the request for a nebulized solution that will be administered via nebulizer in the home setting? Please provide medication, diagnosis, and place of administration.

☐ Yes ☐ No

Q21. Name of Medication:

Q22. What is the patient diagnosis?

Q23. What is the ICD-10 code(s)?

Q24. What is the J-code?

Q25. Requested Duration:

☐ 12 months ☐ Other

Q26. Additional Information:

Prescriber Signature

Date

v2025