## 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:	City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):		
	DITED REVIEW: By checking this box and signing below, I enrollee or the enrollee's ability to regain maximum funct		eview timeframe may seriously jeopardize	
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 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				
Q2. Requeste				
		□ Othor:		
☐ 12 Mont	.ns	☐ Other:		
Q3. Additiona	al Information:			

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Patient Name:	Prescriber Name:		
Prescriber Signature	Date		
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