Jefferson Health Plans

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.

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. Will pegfilgrastim be used as primary prophylaxis against febrile neutropenia?

☐ Yes ☐ No

Q2. Is the patient receiving myelosuppressive chemotherapy (attach documentation)?

☐ Yes ☐ No

Q3. Is the patient at increased risk 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

Q6. Is the patient receiving myelosuppressive chemotherapy with a history of febrile neutropenia during a previous course of chemotherapy for which primary prophylaxis was not received (attach documentation)?

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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