



2024 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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and 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

Q3. Does the member have the diagnosis of HBV?

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



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Patient Name:	Prescriber Name:
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Q5. Additional Information:

Prescriber Signature

Date

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