

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Pegfilgrastim Agents**

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.

PLEASE NO	TE: Any information (patient, prescriber, drug, is	bbs) left blank, megible, or not attached v	VILL delay the review process.	
Patient Name:		Prescriber Name:		
Member Number:		Fax: Phone:		
Date of Birth:		Office Contact:		
Line of Business:	□ Exchange - PA	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:		Specialty/facility name (if applicable):		
	<u>DITED REVIEW</u> : By checking this box and signing below, I lee's ability to regain maximum function.	certify that the standard review timeframe ma	y seriously jeopardize the life or health of	
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		

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Patient Name:	Prescriber Name:		
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)?			
□ 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. Additional Information:			
Prescriber Signature	Date		
	2024 Prior Authorization Request		