Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Fuzeon

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.

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):**

☐ 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.

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 this an initial or continuation request?

☐ Initial - Go to 2 ☐ Continuation - Go to 4

Q2. Does the patient have a diagnosis of HIV-1 infection?

☐ Yes ☐ No

Q3. Does the patient meet one of the following criteria:
A) The patient has viremia despite 3 or more prior months of therapy with at least one appropriate regimen used to treat HIV
B) The patient has viremia and documented resistance or intolerance to at least one appropriate regimen used to treat HIV?

☐ Yes ☐ No

Q4. For reauthorization, has the patient had a positive or stable virologic response to Fuzeon?

☐ Yes ☐ No

Q5. Additional Information

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2025