



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Mircera

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: <input type="checkbox"/> 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. Has the patient been assessed for iron deficiency anemia and is found to have adequate iron stores (defined as a serum transferrin saturation [TSAT] level greater than or equal to 20% within the prior 3 months) or are they receiving iron therapy? Please attach labs/documentation.

☐ Yes

☐ No

Q2. Is the patient using the requested medication concomitantly with other erythropoiesis stimulating agents?

☐ Yes

☐ No

Q3. Request Type:

☐ Initial - Go to 4

☐ Continuation - Go to 5

Q4. Is the patient 18 years of age or older?

☐ Yes

☐ No

Q5. Is the requested medication being used to treat anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL? Please attach documentation.



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Patient Name:	Prescriber Name:
<div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q6. Is the requested medication being used to treat anemia due to CKD in patients 3 months to 17 years of age who are converting from another ESA after their hemoglobin level was stabilized (e.g., Hgb level of 10 to 12 g/dL) with an ESA? Please attach documentation. <div style="display: flex; justify-content: space-between; margin-top: 10px;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q7. Has the patient received at least 12 weeks of Mircera therapy? <div style="display: flex; justify-content: space-between; margin-top: 10px;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q8. Has the patient shown a response to therapy with a rise in hemoglobin of greater than or equal to 1 g/dL ? <div style="display: flex; justify-content: space-between; margin-top: 10px;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q9. Has the patient not yet responded with a rise in hemoglobin of greater than or equal to 1 g/dL? <div style="display: flex; justify-content: space-between; margin-top: 10px;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q10. Is the patient's current hemoglobin less than 12 g/dL? <div style="display: flex; justify-content: space-between; margin-top: 10px;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q11. Additional Information:	

Prescriber Signature

Date

v2025