

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,

| PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, lilegible, 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. 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 - 0 | 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. | | | |

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



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: | | |
|--|------------------|--|--|
| ☐ Yes | □ No | | |
| 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. | | | |
| ☐ Yes | □ No | | |
| Q7. Has the patient received at least 12 weeks of Mircera therapy? | | | |
| ☐ Yes | □ No | | |
| Q8. Has the patient shown a response to therapy with a rise in hemoglobin of greater than or equal to 1 g/dL ? | | | |
| ☐ Yes | □ No | | |
| Q9. Has the patient not yet responded with a rise in hemoglobin of greater than or equal to 1 g/dL? | | | |
| ☐ Yes | □ No | | |
| Q10. Is the patient's current hemoglobin less than 12 g/dL? | | | |
| ☐ Yes | □ No | | |
| Q11. Additional Information: | | | |
| | | | |
| | | | |
| Prescriber Signature | Date | | |

v2025