Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Alpha-1 Proteinase Inhibitors

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 the member 18 years of age or older?

☐ Yes ☐ No

Q2. Does the member have a diagnosis of emphysema due to severe congenital deficiency of Alpha1-PI?

☐ Yes ☐ No

Q3. Has the drug been prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q4. Does the member have Immunoglobulin A (IgA) deficiency with known antibodies to IgA?

☐ Yes ☐ No

Q5. Is there documentation of testing that confirms one of the following homozygous protein phenotypes: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) AND labs that show baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 micromol/L as documented by either of the following: less than 57mg/dL as determined by nephelometry OR less than 80mg/dL as determined by radial immunodiffusion)?

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Alpha-1 Proteinase Inhibitors

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Requested Duration: ☐ 12 months	☐ Other
Q7. Additional Information:	

Prescriber Signature _____ Date _____

v2026