Jefferson Health Plans

# *MEDICARE ADVANTAGE*
## *PRIOR AUTHORIZATION REQUEST FORM*

Pegfilgrastim Agents - Medicare

**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. Will pegfilgrastim be used as primary prophylaxis against febrile neutropenia? If YES, go to 2. If NO, go to 5.

☐ Yes ☐ No

Q2. Is the patient receiving myelosuppressive chemotherapy (attach documentation)? If YES, go to 3.

☐ Yes ☐ No

Q3. Is the patient at increased risk for febrile neutropenia (attach documentation)? If YES, go to 4.

☐ Yes ☐ No

Q4. Is the patient receiving dose-dense or high-dose chemotherapy (attach documentation)? If YES, go to 8.

☐ Yes ☐ No

Q5. Will pegfilgrastim be used as secondary prophylaxis against febrile neutropenia? If YES, go to 6. If NO, go to 7.

Jefferson Health Plans

***MEDICARE ADVANTAGE***
***PRIOR AUTHORIZATION REQUEST FORM***

Pegfilgrastim Agents - Medicare

**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. 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)? If YES, go to 8.

☐ Yes ☐ No

Q7. Is pegfilgrastim being used for a medically accepted indication not otherwise excluded from Part D? If YES, go to 8.

☐ Yes ☐ No

Q8. Will the patient's complete blood count with differential including absolute neutrophil count (ANC) be monitored?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026