Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Deferiprone

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 at the enrollee or the enrollee's ability to regain maximum functions.	and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health on.
Drug Name:	
Strength:	
Directions / SIG:	
	y including labs and information for this member that may support approval. answer the following questions and sign.
Q1. Is deferiprone prescribed by or i	
☐ Yes	□No
Q2. Does the member have docume syndromes, sickle cell disease or other.	entation of transfusional iron overload due to thalassemia ner anemias?
☐ Yes	□No
Q3. Does the member have a docur equal to 1.5 x 1000000000 (10 to the	nentation of Absolute Neutrophil Count (ANC) greater than or e ninth power) per liter?
☐ Yes	□ No
Q4. Additional Information:	
Prescriber Signature	Date

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nt Name:	Prescriber Name:
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2024 Prior Authorization Request