Jefferson Health Plans

2024 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: □ 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 have 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 requested medication being used to treat anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL? Please attach documentation.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. For continuation of therapy for anemia due to chronic kidney disease, is the patient's current hemoglobin less than 12 g/dL and have they shown a response to therapy with a rise in hemoglobin of less than 1 g/dL after at least 12 weeks of ESA therapy?

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request