Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Rukobia

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. Is this an initial or continuation request? [If continuation request, go to 10]

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of HIV-1?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Does the patient have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Will the medication be prescribed by or in consultation with an infectious disease or HIV specialist?

☐ Yes ☐ No

Q7. Will the medication be used in combination with other antiretrovirals?

☐ Yes ☐ No

Q8. Is the patient treatment-experienced with multidrug-resistant HIV-1 infection?

☐ Yes ☐ No

Q9. Is the patient failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations?

☐ Yes ☐ No

Q10. For continuation, is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q11. Is the patient responding positively to therapy?

☐ Yes ☐ No

Q12. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request