Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Ofev

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 request for reauthorization? If YES, go to 2. If NO, go to 4.

☐ Yes ☐ No

Q2. Are liver function tests (ALT, AST, and bilirubin) being monitored periodically throughout the course of treatment as clinically indicated?

☐ Yes ☐ No

Q3. Is there confirmation of positive clinical response to therapy?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of idiopathic pulmonary fibrosis confirmed by biopsy or HRCT? If YES, go to 7. If NO, go to 5.

☐ Yes ☐ No

Q5. Is there documentation showing that the drug will be used to slow the rate of decline in pulmonary function in patients with a diagnosis of systemic sclerosis-associated interstitial lung disease? If YES, go to 7. If NO, go to 6.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype confirmed by HRCT?

☐ Yes ☐ No

Q7. Are documented baseline liver function tests (ALT, AST, and bilirubin) attached?

☐ Yes ☐ No

Q8. Is the requested product being prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q9. Is this a request for a formulary product?

☐ Yes ☐ No

Q10. Is there documentation of an inadequate response, intolerance, or contraindication to all formulary products indicated for the diagnosis that would not be expected to occur with requested agent?

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

v2026

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