Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Tarpeyo

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 request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the diagnosis?

☐ Primary Immunoglobulin A Nephropathy (IgAN)
☐ Other Medically Accepted Indications
☐ Other

Q3. If other, please specify:

Q4. Is there chart notes documenting the diagnosis confirmed by kidney biopsy with biopsy results attached?

☐ Yes ☐ No

Q5. Is the member at risk of rapid disease progression defined as proteinuria >= 0.5 g/day OR urine protein-to-creatinine ratio (UPCR) >= 0.8 g/g with lab results attached?

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☐ Yes ☐ No

Q6. Has the member received a maximally tolerated dose of a renin-angiotensin (RAS) inhibitor (e.g., ACE inhibitor or ARB) for at least 90 days or does the member have an intolerance or contraindication to RAS inhibitors?

☐ Yes ☐ No

Q7. Is the member receiving concomitant therapy with other IgAN therapies (e.g., ACE inhibitor, ARB, Filspari)?

☐ Yes ☐ No

Q8. Is there confirmation of positive clinical response as demonstrated by a reduction in total urine protein from baseline or reduction in UPCR from baseline?

☐ Yes ☐ No

Q9. Is there documentation that the member is receiving concomitant therapy with other IgAN therapies (e.g., ACE inhibitor, ARB, Filspari)?

☐ Yes ☐ No

Q10. Is the medication prescribed by or in consultation with a nephrologist?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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