Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Tarpeyo

Phone: 866-841-7659 **Fax back to: 866-240-3712**

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.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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

Q3. If other, please specify:

Q4. Does the member have a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy (with results attached)?

☐ Yes ☐ No

Q5. Does the member meet ONE of the following criteria within 3 months prior to initiation of the requested drug? Lab reports or chart notes with results must be included.

☐ Proteinuria greater than or equal to 0.5 g/day

☐ UPCR greater than or equal to 0.8 g/g

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Member Name:	Prescriber Name:

☐ None of the above

Q6. Has the member received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or angiotensin II receptor blocker [ARB]) or does the member have an intolerance or contraindication to RAS inhibitors?

☐ Yes ☐ No

Q7. Is the member receiving concomitant therapy with other therapies used to treat IgAN (e.g., ACEI, ARB, Filspari)?

☐ Yes ☐ No

Q8. Is the medication being prescribed by or in consultation with a nephrologist?

☐ Yes ☐ No

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06