Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Xdemvy

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 the request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there medical literature supporting length of treatment requested?

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. Is the drug being prescribed by or in consultation with a specialist (ophthalmologist, optometrist, dermatologist or specialist in treatment of diagnosis)?

☐ Yes ☐ No

Q5. Are chart notes attached documenting a diagnosis of Demodex blepharitis?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient demonstrate ONE of the following signs of Demodex infestation: cylindrical cuff at the root of eyelashes, redness at the lid margin, eyelash misdirection, collarettes?

☐ Yes ☐ No

Q7. Does the patient demonstrate TWO of the following symptoms of Demodex infestation: itching/burning, foreign body sensation, crusting on lashes, blurry vision, irritation/discomfort?

☐ Yes ☐ No

Q8. Has the patient had an adequate trial (4-6 weeks) of all of the following: a) Eyelid cleansing/good hygiene including warm compress massage and b) artificial tears?

☐ Yes ☐ No

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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