Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Estrogens

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 product being requested?

☐ Non-preferred Estrogen
☐ Estrogen for Gender Dysphoria
☐ Estrogen with Quantity Exceeding Limit
☐ Other

Q3. If other, please specify:

Q4. For a non-preferred Estrogen, does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Estrogens approved or medically accepted for the member's diagnosis?

☐ Yes ☐ No

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Q5. For gender dysphoria, is the Estrogen prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?

☐ Yes ☐ No

Q6. Is the Estrogen prescribed in a manner consistent with the current World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People?

☐ Yes ☐ No

Q7. Is there documentation from the prescriber indicating improvement in condition?

☐ Yes ☐ No

Q8. Is the requested Estrogen prescribed for an indication that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q9. Is the requested Estrogen prescribed at a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q10. Does the member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

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