Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Analgesics - Acute Pain Agents

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. The requested drug is being prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q2. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q4. Does member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q5. The member has a history of therapeutic failure of or a contraindication or an intolerance to both of the following: Acetaminophen AND an NSAID.

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. For Journavx (suzetrigine), has the member received a 14-day supply of Journavx (suzetrigine) in the past 90 days.

☐ Yes ☐ No

Q7. If Journavx (suzetrigine) has been used in the past, documentation shows that the beneficiary is experiencing a new episode of moderate to severe acute pain that is separate and distinct from the previous episode that was treated with Journavx (suzetrigine).

☐ Yes ☐ No

Q8. For a non-preferred Analgesics, Acute Pain Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Analgesics, Acute Pain Agents. See the Preferred Drug List for the list of preferred Analgesics, Acute Pain Agents at: https://papdl.com/preferred-drug-list.

☐ Yes ☐ No

Q9. Additional Information:

Prescriber Signature

Date

v2026-06