



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Angiotensin Modulators**

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**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 a request for Qbrelis (lisinopril oral solution) or Epaned (enalapril oral solution)?

Yes

No

Q2. Is the patient less than 9 years of age? [Note: Prior Authorization for Qbrelis (lisinopril oral solution) and Epaned (enalapril oral solution) is not required for patients under 9 years of age.]

Yes

No

Q3. Is this a request for a drug containing aliskiren?

Yes

No

Q4. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. Does the patient have a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximally tolerated Food and Drug Administration (FDA) approved doses unless contraindicated: A) calcium channel blockers, B) beta blockers, C)



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diuretics, D) angiotensin-converting enzyme (ACE) inhibitors, E) angiotensin receptor blockers (ARBs)?

Yes

No

Q6. Is this a request for a preferred angiotensin modulator drug?

Yes

No

Q7. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred angiotensin modulator?

Yes

No

Q8. Is this a request for an angiotensin modulator drug when there is a record of a recent paid claim for an angiotensin modulator combination drug or another angiotensin modulator drug (i.e., potential therapeutic duplication)?

Yes

No

Q9. Is the patient being titrated to, or tapered from, another angiotensin modulator or angiotensin modulator combination?

Yes

No

Q10. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

Yes

No

Q11. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06