



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Antibiotics - Inhaled

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 request for Arikayce, Bethkis, Cayston, Tobi solution, Tobi Podhaler, or tobramycin Pak?

Yes

No

Q2. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred inhaled antibiotics approved for the beneficiary's diagnosis?

Yes

No

Q3. Does the patient have culture and sensitivity test results that document that only a non-preferred inhaled antibiotic will be effective?

Yes

No

Q4. Is this request for tobramycin solution or Kitabis Pak?

Yes

No

Q5. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No



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Q6. Is the requested product age-appropriate according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q7. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q8. Additional Information:

Prescriber Signature

Date

v2026-06