Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Antihistamines - Minimally Sedating

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. Is this a request for minimally-sedating antihistamine when there is a record of a recently paid claim for another minimally-sedating antihistamine drug (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q2. Is the patient being titrated to or tapered from another minimally-sedating antihistamine drug?

☐ Yes ☐ No

Q3. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q4. Is this a request for a preferred minimally-sedating antihistamine drug?

☐ Yes ☐ No

Q5. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred minimally-sedating antihistamine drugs?

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Member Name:	Prescriber Name:

☐ Yes	☐ No
Q6. Additional Information:	

Prescriber Signature _____ Date _____

v2026-06