



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Benign Prostatic Hyperplasia (BPH) Treatments

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. The request is for non-preferred BPH Treatment and the member has a history of therapeutic failure of or a contraindication or an intolerance to the preferred BPH

Yes

No

Q2. For a phosphodiesterase type 5 inhibitor (e.g., tadalafil), both of the following:

Has a diagnosis of BPH

Is prescribed a dose that is consistent with U.S. Food and Drug Administration-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Q3. Additional Information:

Prescriber Signature

Date

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