Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Brinsupri - Non-PDL

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 the request for a reauthorization of Brinsupri? If YES, go to 2. If NO, go to 5.

☐ Yes ☐ No

Q2. The member has a diagnosis of non-cystic fibrosis bronchiectasis (NCFB).

☐ Yes ☐ No

Q3. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist.

☐ Yes ☐ No

Q4. The patient has experienced a positive response to therapy (e.g., reduction in pulmonary exacerbations from baseline).

☐ Yes ☐ No

Q5. The member is 12 years of age or older.

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q7. The member has a documented diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest computed tomography (CT) scan. Attach documentation.

☐ Yes ☐ No

Q8. The member has a documented clinical history consistent with bronchiectasis (chronic cough, chronic sputum production, and/or recurrent RTIs). Attach documentation.

☐ Yes ☐ No

Q9. The member has documentation of one of the following (attach documentation):

☐ a. For 18 years of age and older, the member has experienced at least two (2) exacerbations in the previous 12 months that led to antibiotic treatment

☐ b. For 12 years of age to less than 18 years of age, the member has had at least one (1) pulmonary exacerbation in the previous 12 months that led to antibiotic treatment

Q10. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist.

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

v2026-06