



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

**Bronchodilators - Beta Agonist**

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 a non-preferred oral beta agonist bronchodilator drug?

Yes

No

Q2. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled beta agonist bronchodilators approved or medically accepted for the patient's diagnosis or indication?

Yes

No

Q3. Does the patient have a diagnosis of asthma?

Yes

No

Q4. Does the patient have a concomitant prescription for an inhaled steroid?

Yes

No

Q5. Is this a request for a preferred inhaled long-acting beta agonist bronchodilator drug?

Yes

No



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Member Name:	Prescriber Name:
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Q6. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred long-acting beta agonist bronchodilator drugs?

Yes

No

Q7. Is this a request for an inhaled long-acting beta agonist bronchodilator drug when there is a record of a recent paid claim for another drug containing an inhaled long-acting beta agonist (i.e., potential therapeutic duplication)?

Yes

No

Q8. Is this a request for a non-preferred inhaled short-acting beta agonist bronchodilator drug?

Yes

No

Q9. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled short-acting beta agonist bronchodilator drugs?

Yes

No

Q10. Is the patient being titrated to or tapered from a drug in the same class?

Yes

No

Q11. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

Yes

No

Q12. Additional Information:

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

\_\_\_\_\_  
Date

v2026-06