



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

**Enzyme Replacements - Gaucher Disease**

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 initial therapy with the requested agent?

[If no, skip to question 12.]

Yes

No

Q2. Is the requested drug being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA) – approved package labeling or a medically accepted indication?

Yes

No

Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q4. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. Does the patient have a history of contraindication to the requested drug?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is this request for a non-preferred agent?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Has the patient tried and failed or had a contraindication or intolerance to the preferred agents approved or medically accepted for the patient's indication?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a diagnosis of Gaucher disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have one of the following: A) Enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) activity, B) Deoxyribonucleic acid (DNA) testing confirming the diagnosis? Note: Please attach documentation of the lab test.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have a diagnosis of one of the following: A) Anemia, B) Bone disease, C) Hepatomegaly, D) Interstitial lung disease, E) Splenomegaly, F) Thrombocytopenia? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Has the plan previously approved the requested drug for this patient (previous authorization is on file under this plan)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	



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Member Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q14. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q15. Has the disease severity improved since initiating treatment with the requested drug? Note: Please provide documentation of disease improvement.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q16. Additional Information:

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Prescriber Signature

\_\_\_\_\_  
Date

v2026-06