



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

HIV-AIDS Antiretrovirals

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 the requested drug in the same class of drugs as a drug that the patient is already receiving?

Yes

No

Q2. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred HIV/AIDS Antiretroviral?

Note: Does not apply non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred.

Yes

No

Q3. Does the patient have a documented history of contraindication, intolerance, or lab test results showing resistance to the preferred HIV/AIDS Antiretrovirals with the same mechanism of action as the requested agent?

Yes

No

Q4. Is the requested drug prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling a medically accepted indication?

Yes

No



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Q5. Is the requested dose consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q6. For an NNRTI, is the patient being transitioned to another NNRTI with the intent of discontinuing one of the medications?

Yes

No

Q7. For a protease inhibitor, is the patient being transitioned to another protease inhibitor with the intent of discontinuing one of the medications?

Yes

No

Q8. For an integrase strand transfer inhibitor, is the patient being transitioned to another integrase strand transfer inhibitor with the intent of discontinuing one of the medications?

Yes

No

Q9. For a single product regimen, is the patient being transitioned to another single product regimen with the intent of discontinuing one of the medications?

Yes

No

Q10. Does the patient have a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

Yes

No

Q11. Additional Information:

Prescriber Signature

Date

v2026-06



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