



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - TZDs

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 Hypoglycemic - TZD?

Yes

No

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred Hypoglycemics - TZDs (pioglitazone)?

Yes

No

Q3. Is this a request for a Hypoglycemic - TZD when there is a paid claim for another Hypoglycemic - TZD (i.e., potential therapeutic duplication)?

Yes

No

Q4. Is the patient being transitioned to or from another Hypoglycemic - TZD with the intent of discontinuing one of the medications?

Yes

No

Q5. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

Yes

No



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Member Name:	Prescriber Name:
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Q6. Additional Information:

Prescriber Signature

Date

v2026-06