



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Leukotriene Modifiers

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 montelukast granules?

Yes

No

Q2. Is the patient less than 2 years of age?

[Note: Prior Authorization is not required for patients less than 2 years of age.]

Yes

No

Q3. Is this a request for a preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?

Yes

No

Q4. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?

Yes

No

Q5. Is this a request for a leukotriene modifier when there is a record of a recent paid claim for another leukotriene modifier (i.e., potential therapeutic duplication)?



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| | |
|--------------|------------------|
| Member Name: | Prescriber Name: |
|--------------|------------------|

| | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

| | |
|--|-----------------------------|
| Q6. Is the patient being titrated to, or tapered from, a drug in the same class? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | |
|---|-----------------------------|
| Q7. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| |
|-----------------------------|
| Q8. Additional Information: |
|-----------------------------|

Prescriber Signature

Date

v2026-06