Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Local Anesthetics - Topical

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: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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 lidocaine viscous oral solution or lidocaine oral jelly?

☐ Yes ☐ No

Q2. Is the patient 3 years of age or older?
[Note: Prior Authorization for lidocaine viscous oral solution or lidocaine oral jelly is only required for patients less than 3 years of age.]

☐ Yes ☐ No

Q3. Is the requested drug being prescribed for the treatment of teething pain?

☐ Yes ☐ No

Q4. Does the patient have documented therapeutic failure, contraindication to, or intolerance of alternative recommended treatments for the patient's indication?

☐ Yes ☐ No

Q5. Is the patient prescribed a dose that is consistent with United States Food and Drug Administration (US FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred topical local anesthetic drugs?

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

v2026-06