



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

**Macular Degeneration Agents**

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 medication being used to treat a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA) approved package labeling, or a medically accepted indication?

Yes

No

Q2. Is the requested medication prescribed by a retinal specialist?

Yes

No

Q3. Is the prescribed dose and frequency of the requested medication consistent with the FDA-approved package labeling, nationally recognized compendia, or is medically accepted?

Yes

No

Q4. Is the patient currently receiving treatment with the requested medication?

Yes

No

Q5. Is there documentation of previous date(s) of administration of the requested medication?

Yes

No



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Q6. Does the patient have documentation of a positive clinical response with the requested medication based on the prescriber's assessment?

Yes

No

Q7. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to intravitreal bevacizumab?

Yes

No

Q8. Is the patient unable to use intravitreal bevacizumab because of clinical reasons as documented by the prescriber (e.g., the patient has neovascular (wet) age-related macular degeneration or geographic atrophy)?

Yes

No

Q9. Is the requested medication a non-preferred macular degeneration agent?

Yes

No

Q10. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to the preferred macular degenerative agents approved or medically accepted for the patient's diagnosis?

Yes

No

Q11. Additional Information:

Yes

No

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06