



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

**Non-Preferred Drug - Non-PDL**

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. Has the patient been treated previously with the requested medication?

[If no, then skip to question 7.]

Yes

No

Q2. Has the patient received samples of the requested medication?

[If no, then skip to question 4.]

Yes

No

Q3. Has a sample log for the requested medication been attached including dates, dosage, and directions?

Yes

No

Q4. Has the patient been treated on the requested medication while in a hospital or facility?

[If yes, then skip to question 6.]

Yes

No

Q5. Has the patient received the requested medication through means other than samples or a hospital/facility (e.g., through another insurer)?



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

**Non-Preferred Drug - Non-PDL**

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:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Are medical records attached showing the requested medication being filled, including dates, dosage, and directions?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have a contraindication to the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the requested medication have step therapy requirements? [If no, then skip to question 9.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has the patient tried and failed the medication(s) required for step therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the medication being used for an FDA approved indication or for use supported by nationally recognized pharmacy compendia, or peer-reviewed medical literature (diagnosis must be attached)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is this a request for a formulary medication? [If yes, then skip to question 12.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Are the medications, that the patient tried and failed, listed (for each medication, please state the adverse outcome or type of failure and dates of trial)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Are relevant labs or diagnostic test results attached?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No



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

**Non-Preferred Drug - Non-PDL**

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:
--------------	------------------

Q14. Additional Information:

Q15. INTERNAL QUESTION: Type \*

Brand  Generic

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

\_\_\_\_\_  
Date

v2026-06