



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Oncology Agents - Breast Cancer

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 letrozole or Femara?

Yes

No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?
[Note: Documentation from the medical record of the diagnosis is required for approval.]

Yes

No

Q3. Is the requested drug being prescribed to promote fertility?

Yes

No

Q4. Is this a request for a preferred breast cancer oncology drug?

Yes

No

Q5. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred breast cancer oncology drugs?

Yes

No



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Member Name:	Prescriber Name:
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Q6. Additional Information:

Prescriber Signature

Date

v2026-06