



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

**Ophthalmics - Anti-Inflammatories**

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:		

*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. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to one of the preferred Ophthalmics, Anti-Inflammatories that are Food and Drug Administration (FDA)-approved or medically accepted for the patient's diagnosis or indication?

Yes

No

Q2. Is the requested drug an intravitreal implant or injection?

Yes

No

Q3. Is the requested drug being prescribed for an indication that is included in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No

Q4. Is the patient age-appropriate according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No



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Q5. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q6. Is the requested drug prescribed by an ophthalmologist?

Yes

No

Q7. Additional Information:

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

\_\_\_\_\_  
Date

v2026-06