Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Opioid Dependence Treatments

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. Type of request:

☐ New Request ☐ Renewal Request

Q2. Diagnosis Code:

Q3. Diagnosis:

Q4. For a NON-PREFERRED SUBLINGUAL buprenorphine product (eg, film, tablet):

Tried and failed or has a contraindication or an intolerance to the preferred SUBLINGUAL buprenorphine Opioid Use Disorder Treatments (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)

☐ Yes ☐ No ☐ N/A

Q5. For a non-preferred NON-SUBLINGUAL buprenorphine product (eg, injection):

Tried and failed or has a contraindication or an intolerance to the preferred NON-SUBLINGUAL

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Member Name:	Prescriber Name:

buprenorphine Opioid Use Disorder Treatments (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)

☐ Yes ☐ No ☐ N/A

Q6. For Lucemyra (lofexidine):

Tried and failed or has a contraindication or an intolerance to clonidine tablet

☐ Yes ☐ No ☐ N/A

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06

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