MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Phosphate Lowering 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: ☐ 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. For a non-preferred Phosphate Lowering Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Phosphate Lowering Agents (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class).

☐ Yes ☐ No

Q2. Additional Information:

Prescriber Signature

Date

v2026-06