Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Progestational 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. Is the request for a non-preferred progestational agent?

☐ Yes ☐ No

Q2. Is the medication for intravaginal use?

☐ Yes ☐ No

Q3. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of the preferred progestational agents approved or medically accepted for the patient's indication?

☐ Yes ☐ No

Q4. Is the requested intravaginal progestational agent being prescribed for treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labeling OR a medically accepted indication, excluding use to promote fertility?

☐ Yes ☐ No

Q5. Additional Information:

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Member Name:	Prescriber Name:

_____ _____

Prescriber Signature Date

v2026-06