



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Pulmozyme - Non-PDL

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 the requested drug being prescribed by or in consultation with a pulmonologist?

Yes

No

Q2. Does the patient have a diagnosis of cystic fibrosis? (Please attach documentation of diagnosis)?

Yes

No

Q3. Is Pulmozyme being prescribed in conjunction with standard therapies (such as CFTR [cystic fibrosis transmembrane conductance regulator] modulators, oral, inhaled and/or parenteral antibiotics, bronchodilators, pancreatic enzyme supplements, vitamins, oral or inhaled corticosteroids, inhaled hypertonic saline, analgesics, and chest physiotherapy) for cystic fibrosis?

Yes

No

Q4. Will the requested drug be administered using a recommended jet nebulizer/compressor system or eRapid Nebulizer System?

Yes

No

Q5. Is the requested drug being prescribed at a dose of 2.5 mg once daily?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the requested drug being prescribed at a dose of 2.5 mg twice daily?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Has documentation of an adequate trial of once daily dosing consisting of at least a 2 week trial been submitted? [Please attach documentation of previous trial.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Additional Information:	

Prescriber Signature

Date

v2026-06