



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

**Quantity Limit Exceptions**

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. Does the provider offer clinical rationale to substantiate why Health Partners' quantity limit is not adequate to treat the patient based on condition and treatment history? (Please attach supporting documentation).

Yes

No

Q2. Is the quantity requested at a dose that is within prescribing guidelines but exceeds Health Partners' quantity limits?

Yes

No

Q3. Can the requested drug therapy be satisfied within the plan's quantity limits at a different strength of the same drug?

Yes

No

Q4. Does the patient have a documented history of treatment failure with the requested drug being prescribed within Health Partners' quantity limits?

Yes

No

Q5. Would a trial of the requested drug within Health Partners' quantity limits be detrimental to your patient's health? (Please attach explanation).



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Yes

No

Q6. Is the quantity requested to treat your patient's condition at a dose that can be medically supported (by recognized compendia, peer-reviewed literature, or standard of care guidelines)? (Please attach supporting documentation).

Yes

No

Q7. Additional Information:

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

\_\_\_\_\_  
Date

v2026-06