Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Tavneos - 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: ☐ 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 patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q2. Is this a request for a renewal? If YES, go to question 3. If NO, go to question 4.

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and/or tolerance to the requested medication?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is there documentation of an active diagnosis of severe active ANCA-associated vasculitis of one of the following types?

a. Granulomatosis with polyangiitis (GPA)
b. Microscopic polyangiitis (MPA)

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Member Name:	Prescriber Name:

☐ Yes	☐ No
Q6. Is there documentation that this will be used as adjunctive OR in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide)?	
☐ Yes	☐ No
Q7. Is the medication prescribed by or in consultation with rheumatologist, nephrologist, or immunologist?	
☐ Yes	☐ No
Q8. Does the patient have Eosinophilic Granulomatosis with Polyangiitis (EGPA), also known as Churg-Strauss syndrome?	
☐ Yes	☐ No
Q9. Additional Information:	

_____ _____

Prescriber Signature Date

v2026-06