



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Urea Cycle Disorder 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: <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 this a request for continuation of therapy with the requested drug (i.e., this medication was previously approved by a HPP prior authorization)?

Yes

No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No

Q3. Is there chart documentation supporting the diagnosis (e.g., ammonia levels, genetic testing, enzyme assays, plasma amino acid/urine orotic acid analyses, progress notes)?

Yes

No

Q4. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. If the requested drug a non-preferred urea cycle disorder agent?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred urea cycle disorder agent?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is there documentation from the prescribing provider that the beneficiary had a positive clinical response to therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested drug prescribed by or in consultation with a physician who specializes in treating metabolic disorders?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Requested Duration:	
<input type="checkbox"/> 12 Months	
Q11. Additional Information:	

Prescriber Signature

Date

v2026-06