



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Vioice - 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 this a request for a renewal? If YES, go to 7.

Yes

No

Q2. Is the patient 2 years of age or older?

Yes

No

Q3. Does the patient have a diagnosis of PIK3CA Related Overgrowth Spectrum (PROS) with chart notes attached?

Yes

No

Q4. Are labs attached confirming presence of a mutation in the PIK3CA gene or likely pathogenic variant as confirmed by genetic testing?

Yes

No

Q5. Does the patient have severe manifestations of PROS (e.g., severe vascular malformations, chronic gastrointestinal bleeding, severe dyspnea, disabling chronic pain, severe epilepsy, severe manifestations despite previous debulking surgery, excessive tissue growth, scoliosis, vascular tumors, cardiac or renal manifestations, and those that require systemic treatment)?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the medication prescribed by, or in consultation with, a physician that specializes in treatment of genetic disorders?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is there documentation of positive clinical response to Vioice™ therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is there documentation that the patient has not experienced disease progression while receiving Vioice™?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the medication prescribed by, or in consultation with, a physician that specializes in the treatment of genetic disorders?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information:	

Prescriber Signature

Date

v2026-06