



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Xdemvy - 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 request for reauthorization? If YES, go to question 2. If NO, go to question 3.

Yes

No

Q2. Is there peer-reviewed medical literature supporting length of treatment requested?

Yes

No

Q3. Is the patient greater than or equal to 18 years of age?

Yes

No

Q4. Is the drug being prescribed by or in consultation with a specialist (ophthalmologist, optometrist, dermatologist or specialist in treatment of diagnosis)?

Yes

No

Q5. Is there documentation of diagnosis of Demodex blepharitis?

Yes

No



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Member Name:	Prescriber Name:
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Q6. Does the patient demonstrate one of the following signs of Demodex infestation: cylindrical cuff at the root of eyelashes, eyelash loss, redness at the lid margin, eyelash misdirection, collarettes?

Yes

No

Q7. Does the patient demonstrate two of the following symptoms of Demodex infestation: itching/burning, foreign body sensation, crusting on lashes, tearing/lacrimation, dryness, purulence/discharge, blurry vision, irritation/discomfort?

Yes

No

Q8. Additional Information:

Prescriber Signature

Date

v2026-06