Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Cayston

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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 patient have documentation of a diagnosis of cystic fibrosis (CF)?

☐ Yes ☐ No

Q2. Is the medication being prescribed by or in consultation with a pulmonologist, a physician who specializes in the treatment of cystic fibrosis (CF), or an infectious disease specialist?

☐ Yes ☐ No

Q3. Does the patient have a lung infection with airway cultures positive for Pseudomonas aeruginosa (with documentation attached)?

☐ Yes ☐ No

Q4. Additional Information:

Prescriber Signature

Date

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Cayston

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**

v2026