Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Journavx

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. The request is for initial treatment with Journavx. If YES, go to 2. If NO, for reauthorization, go to 9.

☐ Yes ☐ No

Q2. The member is 18 years of age or older. If YES, go to 3.

☐ Yes ☐ No

Q3. The member is prescribed Journavx for an indication of moderate to severe acute pain. If YES, go to 4.

☐ Yes ☐ No

Q4. Documentation is attached confirming Journavx will not be used to treat chronic pain. If YES, go to 5.

☐ Yes ☐ No

Q5. Documentation is attached showing that the patient has tried and failed at least two of the following medications within the last 30-days:

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Journavx
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:**

a. oral non-steroidal anti-inflammatory drugs (NSAIDs)
b. topical diclofenac sodium gel
c. acetaminophen
d. tramadol
e. opioids
If YES, go to 7. If NO, go to 6.

☐ Yes ☐ No

Q6. If the patient has not tried and failed at least two alternative drugs: documentation showing the patient has a contraindication or intolerance to all the following:
a. oral non-steroidal anti-inflammatory drugs (NSAIDs)
b. topical diclofenac sodium gel
c. acetaminophen
d. tramadol
e. opioids
If YES, go to 7.

☐ Yes ☐ No

Q7. Documentation is attached showing the dose is not to exceed 150 mg (3 tablets) on day 1, then 100 mg (2 tablets) per day. If YES, go to 8.

☐ Yes ☐ No

Q8. Documentation is attached showing the requested treatment duration is for 14 days or less.

☐ Yes ☐ No

Q9. For reauthorization: Documentation is attached showing the patient is experiencing a new episode of moderate to severe acute pain, separate and distinct from the previous episode. If YES, go to 10.

☐ Yes ☐ No

Q10. Documentation is attached showing that the patient has previously had a positive clinical response to therapy. If YES, go to 11.

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Journavx

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:**

☐ Yes	☐ No
Q11. Documentation is attached showing the dose is not to exceed 150 mg (3 tablets) on day 1, then 100 mg (2 tablets) per day. If YES, go to 12	
☐ Yes	☐ No
Q12. Documentation is attached showing the requested treatment duration is for 14 days or less.	
☐ Yes	☐ No
Q13. Additional Information:	

_____ _____

Prescriber Signature Date

v2025