Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Mifepristone

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. Request Type:

☐ Initial - Go to 2 ☐ Renewal - Go to 11

Q2. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The member is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q4. The member has a diagnosis of uncontrolled hyperglycemia secondary to endogenous Cushing's syndrome.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. The member has type 2 diabetes mellitus or glucose intolerance confirmed by fasting blood glucose, oral glucose tolerance test, or hemoglobin A1c.

☐ Yes ☐ No

Q6. The drug is being prescribed by or in consultation with an appropriate specialist such as an endocrinologist.

☐ Yes ☐ No

Q7. The member is not pregnant;

☐ Yes ☐ No

Q8. The member has failed or is not a candidate for pituitary surgery.

☐ Yes ☐ No

Q9. The member has a history of therapeutic failure, contraindication, or intolerance to ketoconazole, Lysodren, or Metopirone.

☐ Yes ☐ No

Q10. BRAND REQUESTS: If the request is for a brand agent with an available generic equivalent: (check all that apply)

☐ The patient has an intolerance, hypersensitivity, or contraindication to the generic drug that is not expected to occur with the brand drug (chart notes/medical records required).

☐ There is support for the use of the non-formulary drug over the therapeutically equivalent formulary drug (chart notes/medical records required).

Q11. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q12. The drug is being prescribed by or in consultation with an appropriate specialist such as an endocrinologist

☐ Yes ☐ No

Q13. The member is not pregnant.

☐ Yes ☐ No

Q14. The member continues to be treated for diabetes mellitus or elevated glucose with anti-diabetic drugs.

☐ Yes ☐ No

Q15. The member has had a positive clinical response as evidenced by improved fasting blood glucose, oral glucose tolerance test, or hemoglobin A1c.

☐ Yes ☐ No

Q16. BRAND REQUESTS: If the request is for a brand agent with an available generic equivalent: (check all that apply)

☐ • The patient has an intolerance, hypersensitivity, or contraindication to the generic drug that is not expected to occur with the brand drug (chart notes/medical records required).

☐ • There is support for the use of the non-formulary drug over the therapeutically equivalent formulary drug (chart notes/medical records required).

Q17. Additional Information:

Prescriber Signature

Date

v2026