Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Non-Formulary Exceptions and Tiering

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. Is this a request for continuation of therapy? If YES, go to 2. If NO, go to 6.

☐ Yes ☐ No

Q2. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The member has a history of therapeutic failure, contraindication, or intolerance to any new or additional formulary alternatives previously not addressed [Note: Please specify the drug(s) contraindicated or tried, adverse outcomes for each, and if a therapeutic failure, the length of therapy for each drug.]

☐ Yes ☐ No

Q4. Documentation is attached showing the member has had a positive clinical response to therapy.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Are lab results or testing consistent with monitoring parameters established in the package insert and current medically accepted guidelines attached?

☐ Yes ☐ No ☐ NA

Q6. The requested drug is being prescribed to treat a member with stage IV advanced, metastatic cancer with its use being consistent for an FDA-approved indication, the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage IV advanced, metastatic cancer, and/or is supported by peer-reviewed medical literature.

☐ Yes ☐ No

Q7. The drug is being prescribed for an FDA-approved or nationally recognized compendia supported indication OR is its use supported by peer-reviewed medical literature.

☐ Yes ☐ No

Q8. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q9. The member has had an inadequate response, inability to tolerate, or is unable to use ALL available formulary alternatives (documentation must be provided).

☐ Yes ☐ No

Q10. If applicable, the member has a history of therapeutic failure, contraindication, or an intolerance to first-line therapy(ies) according to consensus treatment guidelines.

☐ Yes ☐ No ☐ NA

Q11. Relevant labs or diagnostic test results are attached, as appropriate?

☐ Yes ☐ No

Q12. Requested Duration:

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Patient Name:	**Prescriber Name:**

☐ 12 Months	☐ Other:
Q13. Additional Information:	

Prescriber Signature _____ Date _____

v2025