Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Opipza Oral Film

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 member is prescribed Opipza oral film for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication. If YES, go to 2.

☐ Yes ☐ No

Q2. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. If YES, go to 3.

☐ Yes ☐ No

Q3. The member is within the age group listed in the FDA labeling for the indication. If YES, go to 4.

☐ Yes ☐ No

Q4. Documentation is attached showing inability to or difficulty with swallowing solid dosage forms. If YES, go to 5.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is the request for a diagnosis schizophrenia OR adjunctive treatment of major depressive disorder (MDD)? If YES, go to 6. If NO, go to 8.

☐ Yes ☐ No

Q6. Is there documentation attached showing inadequate response, intolerance, or contraindication to generic aripiprazole? If YES, go to 7.

☐ Yes ☐ No

Q7. Is there documentation attached showing inadequate response, intolerance, or contraindication to at least two other generic atypical antipsychotics indicated for the patient's condition?

☐ Yes ☐ No

Q8. Is the request for treatment of Tourette's disorder OR irritability associated with autistic disorder? If YES, go to 9.

☐ Yes ☐ No

Q9. Is there documentation attached showing inadequate response, intolerance or contraindication to generic aripiprazole?

☐ Yes ☐ No

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2025