

**PRIOR AUTHORIZATION REQUEST FORM**

Individual and Family Plans

**GLP-1 Agonists - Exchange**

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: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**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 the requested medication being used for weight loss?**

Yes  No

**Q2. Does the patient have a documented diagnosis of type 2 diabetes mellitus? Must attach documentation.**

Yes  No

**Q3. Is the request for a non-formulary drug?**

Yes  No

**Q4. Is there documentation of inadequate response, intolerance, or contraindication to all formulary drugs? Must attach documentation.**

Yes  No

**Q5. Additional Information:**

**PRIOR AUTHORIZATION REQUEST FORM**

Individual and Family Plans

**GLP-1 Agonists - Exchange**

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:
---------------	------------------

\_\_\_\_\_  
Prescriber Signature\_\_\_\_\_  
Date

v2026