



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Jublia

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, 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.

Form with fields: 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 drug being prescribed for onychomycosis of the toenail(s) due to trichophyton rubrum or trichophyton mentagrophytes?

Yes checkbox

No checkbox

Q2. Has the patient's diagnosis been confirmed with a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?

Yes checkbox

No checkbox

Q3. Has the patient experienced an inadequate treatment response to an oral antifungal therapy (e.g., terbinafine, itraconazole)?

Yes checkbox

No checkbox

Q4. Has the patient experienced an intolerance to an oral antifungal therapy (e.g., terbinafine, itraconazole)?

Yes checkbox

No checkbox



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Jublia

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:
Q5. Does the patient have a contraindication that would prohibit a trial of an oral antifungal therapy (e.g., terbinafine, itraconazole)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the requested drug being used in a footbath?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Additional Information:	

Prescriber Signature

Date

v2025