Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Quantity Limits Exception

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. Does the provider offer clinical rationale to substantiate why Jefferson Health Plans quantity limit is not adequate to treat the patient based on condition and treatment history? (Please attach supporting documentation).

☐ Yes ☐ No

Q2. Is the quantity requested at a dose that is within prescribing guidelines but exceeds Jefferson Health Plans quantity limits?

☐ Yes ☐ No

Q3. Can the requested drug therapy be satisfied within the plan's quantity limits at different strength(s) of the same drug?

☐ Yes ☐ No

Q4. Does the patient have a documented history of treatment failure with the requested drug being prescribed within Jefferson Health Plans quantity limits?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Would a trial of the requested drug within Jefferson Health Plans quantity limits be detrimental to your patient's health? (Please attach explanation).

☐ Yes ☐ No

Q6. Is the quantity requested to treat your patient's condition at a dose that can be medically supported (by recognized compendia, peer-reviewed literature, or standard of care guidelines)? (Please attach supporting documentation).

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request