Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Early Refills

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 patient require an early refill due to a temporary absence from the Commonwealth OR the United States for an extended period of time that is greater than the remaining day supply of the earlier dispensed medication or medical supplies?
[Note: Documentation of the patient's destination and duration of absence is required for approval. If the patient is traveling within the United States, an early refill will be dependent on that State's Pharmacy Laws and Regulations.]

☐ Yes ☐ No

Q2. Is this a request for a medication that could potentially be detrimental to the patient's health and safety if used in large quantities (e.g., controlled substances, sleep aids, etc.)?

☐ Yes ☐ No

Q3. Does the patient require an early refill due to a change in therapy?
[Note: If yes, then documentation of a change in dosage of the medication and/or medical supply, an increase in the dosing frequency, or the number of units per dose is required for approval.]

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q4. Does the patient require an early refill because the medication or medical supplies were lost?
[Note: If yes, then documentation describing what medication(s) and/or medical supplies were lost and a description of the event that occurred (when, where, time, date, circumstance) is required for approval.]

☐ Yes ☐ No

Q5. Does the patient require an early refill because the medication or medical supplies were stolen?
[Note: If yes, then documentation describing what medication(s) and/or medical supplies were stolen, a description of the event that occurred (when, where, time, date, circumstance), and an attached police report are required for approval.]

☐ Yes ☐ No

Q6. Does the patient require an early refill because the medication or medical supplies were destroyed?
[Note: If yes, then documentation describing what medication(s) and/or medical supplies were destroyed, a description of the event that occurred (when, where, time, date, circumstance), and a copy of the insurance report (if the destruction is caused by a natural disaster such as a flood, tornado, or hurricane) or a letter from the Red Cross (if the destruction is caused by fire) is required for approval.]

☐ Yes ☐ No

Q7. Does the patient require an early refill for a medication that is life sustaining?
[Note: If yes, then the prescriber must provide information that demonstrates that the medication is life sustaining (examples: a diagnosis of HIV, organ transplant) or is indicated for a psychiatric diagnosis (examples: schizophrenia or other mental illness).]

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

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