



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Vemlidy

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:	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.

<p>Q1. Is this a renewal request?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient responding positively to therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have a diagnosis of chronic hepatitis B with compensated liver disease?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is the patient 12 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Patient Name:	Prescriber Name:
Q6. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have a contraindication to the prescribed drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to other drugs such as entecavir, lamivudine, and Viread?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Additional Information:	

Prescriber Signature

Date

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