



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Zepatier

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.

Q1. Is the member prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, current AASLD-IDSA HCV guidance, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q2. Does the member have a contraindication to the prescribed drug?

Yes

No

Q3. Does the member have the diagnosis of chronic HCV?

Yes

No

Q4. Does the member have documentation of HCV treatment history and documentation of previous HCV treatment regimens if the member has received prior HCV treatment?

Yes

No

Q5. Does the member have documented results of the following?

a. HCV genotype 1b or 4



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| | |
|--|-------------------------|
| Patient Name: | Prescriber Name: |
| b. Quantitative HCV RNA c. Complete blood count (CBC) d. International normalized ratio (INR) e. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels) f. Metavir fibrosis score documented by a recent noninvasive test (e.g., blood test or imaging, a Fibroscan, or findings on physical examination) g. Hepatitis B surface antigen (HBsAg) h. HIV antigen/antibody test <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q6. Additional Information: | |

Prescriber Signature

Date

v2025