



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Livtency - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour 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><b>Q1. Is this a reauthorization request?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q2. Is there confirmation of continued positive clinical response since starting the drug?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q3. Is the patient 12 years of age or older?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q4. Does the patient have a diagnosis of active cytomegalovirus (CMV) infection or disease?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q5. Has the patient undergone hematopoietic stem cell transplant or solid organ transplant?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q6. Is the patient currently taking ganciclovir or valganciclovir?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Member Name:</b>	<b>Prescriber Name:</b>
Q7. Is the drug being prescribed by or in consultation a transplant specialist, infectious disease specialist, hematologist, or oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is there documentation showing infection or disease is refractory or resistant to treatment with one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is there documentation of an inadequate response, intolerance, or contraindication to one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is there documentation showing only Livtency will be effective for CMV infection or disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025