Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Livtencity - 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 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.

Q1. Is this a reauthorization request?

☐ Yes ☐ No

Q2. Is there confirmation of continued positive clinical response since starting the drug?

☐ Yes ☐ No

Q3. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of active cytomegalovirus (CMV) infection or disease?

☐ Yes ☐ No

Q5. Has the patient undergone hematopoietic stem cell transplant or solid organ transplant?

☐ Yes ☐ No

Q6. Is the patient currently taking ganciclovir or valganciclovir?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q7. Is the drug being prescribed by or in consultation a transplant specialist, infectious disease specialist, hematologist, or oncologist?

☐ Yes ☐ No

Q8. Is there documentation showing infection or disease is refractory or resistant to treatment with one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet?

☐ Yes ☐ No

Q9. Is there documentation of an inadequate response, intolerance, or contraindication to one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet?

☐ Yes ☐ No

Q10. Is there documentation showing only Livtencity will be effective for CMV infection or disease?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 12 months ☐ Other:

Prescriber Signature

Date

v2025