

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Ledipasvir-Velpatasvir and Harvoni

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.

Prescriber Name: Member Number:	PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached will delay the review process.		
Date of Birth: Diffice Contact:	Patient Name:	Prescriber Name:	
Line of Business:	Member Number:	Fax: Phone:	
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 he 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	Date of Birth:	Office Contact:	
City, State ZIP: City, State ZIP: Specialty/facility name (if applicable):	Line of Business: □ Exchange - PA	NPI: State Lic ID:	
Primary Phone: Specialty/facility name (if applicable):	Address:	Address:	
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·	☐ Yes	□ No	
☐ Yes ☐ No	□Yes	□No	
Q5. Does the member have documented results of the following? a. HCV genotype 1, 4, 5, or 6			

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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 aminotransferase, and alkaline phosphatase levels. Metavir fibrosis score documented by a recent Fibroscan, or findings on physical examination) g. Hepatitis B surface antigen (HBsAg) h. HIV antigen/antibody test	els)
☐Yes	□ No
Q6. Additional Information:	
Prescriber Signature	Date 2024 Prior Authorization Request