Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ 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 1, 4, 5, or 6

Jefferson Health Plans

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.

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

☐ Yes ☐ No

Q6. Additional Information:

_____ _____

Prescriber Signature Date