Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Somavert

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 this an initial or continuation request?

☐ Initial - Go to 3 ☐ Continuation - Go to 2

Q2. Has the patient's IGF-1 level decreased or normalized since initiation of therapy? Attach labs or chart notes to confirm.

☐ Yes ☐ No

Q3. Is the patient diagnosed with acromegaly?

☐ Yes ☐ No

Q4. Does the patient have a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range with laboratory report included?

☐ Yes ☐ No

Q5. Has the patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy (attach chart notes to confirm)?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No

Q6. Additional Information:

Prescriber Signature

Date

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