



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Vemlidy

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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

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.

Form with fields for Drug Name, Strength, and 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 renewal request?

Yes checkbox

No checkbox

Q2. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q3. Is the patient responding positively to therapy?

Yes checkbox

No checkbox

Q4. Does the patient have a diagnosis of chronic hepatitis B with compensated liver disease?

Yes checkbox

No checkbox

Q5. Is the patient 12 years of age or older?

Yes checkbox

No checkbox



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Form with fields for Patient Name and Prescriber Name.

Q6. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q7. Does the patient have a contraindication to the prescribed drug?

Yes checkbox

No checkbox

Q8. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to other drugs such as entecavir, lamivudine, and Viread?

Yes checkbox

No checkbox

Q9. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request