



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Somavert - 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: <input type="checkbox"/> 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.**

<p>Q1. Is the request for Somavert for reauthorization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Has the patient had a positive clinical response to Somavert?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have a documented diagnosis of acromegaly?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is Somavert being prescribed by or in consultation with an endocrinologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender above the upper limit of normal based on laboratory reference range?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient had an inadequate response to surgery or radiation therapy?</p>



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is there a clinical reason why the patient has not had surgery or radiation therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is there documentation of an inadequate response, intolerance, or contraindication to octreotide?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Requested Duration:	
<input type="checkbox"/> 12 months	<input type="checkbox"/> Other:
Q10. Additional Information:	

Prescriber Signature

Date

v2025