Jefferson Health Plans

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.

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 a renewal request?

☐ Yes ☐ No

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 ☐ No

Q3. Is the patient responding positively to therapy?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q5. Is the patient 6 years (and weighs at least 25 kg) of age or older?

☐ Yes ☐ No

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Patient Name:	**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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2025