Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Verquvo - 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: □ 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.

Q1. Is the request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the member had a positive clinical response to therapy?

☐ Yes ☐ No

Q3. Is documentation attached showing that the member has symptomatic chronic heart failure with NYHA Class II to IV?

☐ Yes ☐ No

Q4. Does the patient have a left ventricular ejection fraction (LVEF) less than 45 percent?

☐ Yes ☐ No

Q5. Has the patient had a hospitalization for heart failure within the past 6 months?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Has the patient required use of outpatient intravenous diuretics for heart failure within the past 3 months?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other:

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2026