



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: <input type="checkbox"/> 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 the request for Somavert for reauthorization?

☐ Yes

☐ No

Q2. Has the patient had a positive clinical response to Somavert?

☐ Yes

☐ No

Q3. Does the patient have a documented diagnosis of acromegaly?

☐ Yes

☐ No

Q4. Is Somavert being prescribed by or in consultation with an endocrinologist?

☐ Yes

☐ No

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?

☐ Yes

☐ No



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Patient Name:	Prescriber Name:
Q6. Has the patient had an inadequate response to surgery or radiation therapy? <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. Additional Information:	

Prescriber Signature

Date

v2025