Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Skyrizi

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 an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. Are chart notes documenting the diagnosis attached?

☐ Yes ☐ No

Q3. Is the member within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q4. Is the medication prescribed by or in consultation with an appropriate specialist for the indication: dermatologist, rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q5. Is the member using another biologic Disease Modifying Anti-Rheumatic Drug (bDMARD) or a targeted synthetic DMARD (tsDMARD) concomitantly?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. What is the diagnosis?

- ☐ Moderate to Severe Plaque Psoriasis (PsO)
- ☐ Active Psoriatic Arthritis (PsA)
- ☐ Crohn's Disease (CD)
- ☐ Ulcerative Colitis (UC)
- ☐ Other

Q7. If other, please specify:

Q8. For the diagnosis Moderate to Severe Plaque Psoriasis (PsO), is there documentation of inadequate response, intolerance, or contraindication to at least one of the following: methotrexate, UVB therapy, or acitretin OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q9. For active psoriatic arthritis (PsA), is there documentation of one of the following: inadequate response, intolerance, or contraindication to a conventional DMARD (e.g., methotrexate, leflunomide, or sulfasalazine) OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q10. Does the member have axial disease, dactylitis, and/or enthesitis?

☐ Yes ☐ No

Q11. Does the member have severe disease as determined by the prescriber?

☐ Yes ☐ No

Q12. Does the member have concomitant moderate to severe nail disease?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q13. Does the member have concomitant active inflammatory bowel disease?

☐ Yes ☐ No

Q14. For Crohn's disease (CD) and ulcerative colitis (UC), do chart notes document that the disease is moderate to severe OR the disease is mild with poor prognostic features?

☐ Yes ☐ No

Q15. For all diagnoses, is there confirmation of positive clinical response?

☐ Yes ☐ No

Q16. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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