



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Antipsoriatics - Topical

Phone: 866-841-7659

Fax back to: 866-240-3712

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 ID Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Phone Number: | NPI: | PA PROMISe ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP | Specialty Pharmacy (if applicable): | |
| Drug Name: | Strength: | |
| Quantity: | Refills: | |
| Directions: | | |
| Diagnosis Code: | Diagnosis: | |

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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. The request is for renewal of the Antipsoriatics, topical that was previously approved. If YES, go to 14. If NO, go to 2.

Yes

No

Q2. The member meets ALL of the following:

Is prescribed the Antipsoriatic, Topical for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication

Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature

Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Does not have a contraindication to the prescribed drug

Q3. What type of drug is being requested?

For a topical AHR agonist, go to 4.

For a topical PDE4 Inhibitor, go to 8.

For all other non-preferred Antipsoriatics, Topical, go to 13.

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Q4. For a TOPICAL AHR AGONIST (e.g., tapinarof), for treatment of PSORIASIS, has a history of therapeutic failure of or a contraindication or an intolerance to BOTH of the following:

If YES, go to 6. If NO, go to 5.

- | | |
|--|---|
| <input type="checkbox"/> A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis | <input type="checkbox"/> An eight-week trial of a non-steroidal topical pharmacologic product approved or medically accepted for the treatment of the beneficiary's diagnosis (e.g., topical calcineurin inhibitor, topical retinoid, topical vitamin D analog) |
|--|---|

Q5. For a TOPICAL AHR AGONIST (e.g., tapinarof), for treatment of ALL OTHER DIAGNOSES, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines.

- | | |
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| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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Q6. The request is for a PREFERRED TOPICAL AHR AGONIST.

- | | |
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| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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Q7. For a NON-PREFERRED TOPICAL AHR AGONIST, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis.

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| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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Q8. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) for treatment of PSORIASIS, has a history of therapeutic failure of or a contraindication or an intolerance to topical calcipotriene. If YES, go to 11. If NO, go to 9.

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| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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Q9. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) for treatment of SEBORRHEIC DERMATITIS, has a history of therapeutic failure of or a contraindication or an intolerance to at least ONE of the following:

- A four-week trial of a topical antifungal approved or medically accepted for the treatment of the beneficiary's diagnosis,

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| <input type="checkbox"/> A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis, <input type="checkbox"/> A four-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis, |
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| Q10. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) for treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines. <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q11. The request is for a PREFERRED TOPICAL PDE4 INHIBITOR. <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q12. For a NON-PREFERRED TOPICAL PDE4 INHIBITOR, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis. <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q13. For ALL OTHER NON-PREFERRED ANTIPSORIATICS, TOPICAL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis; <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q14. The member has documentation of a positive clinical response to the prescribed drug. <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q15. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Q16. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis. |
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Yes

No

Q17. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis.

Yes

No

Q18. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis.

Yes

No

Q19. Additional Information:

Prescriber Signature

Date

v2026-06