



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Taltz

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax: Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, 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.

Form with fields: 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 reauthorization request?

Yes No

Q2. Is there confirmation of continued positive clinical response since starting Taltz?

Yes No

Q3. Is the medication prescribed by or in consultation with a dermatologist or rheumatologist?

Yes No

Q4. Is there a confirmation of tuberculosis (TB) screening results and treatment plan for active or latent infection?

Yes No

Q5. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis (PsO)?

Yes No

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|  |                         |
|--|-------------------------|
| <b>Patient Name:</b>   | <b>Prescriber Name:</b> |
| Q6. Is the patient 6 to 17 years of age?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                         |
| Q7. Is there documentation of an inadequate response, intolerance or contraindication to Enbrel?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                     |                         |
| Q8. Is the patient 18 years of age or older?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                         |
| Q9. Is there documentation of an inadequate response, intolerance or contraindication to Humira, Enbrel OR Skyrizi?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                  |                         |
| Q10. Does the patient have a confirmed diagnosis of active psoriatic arthritis (PsA)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q11. Is the patient 18 years of age or older?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q12. Is there documentation of inadequate response, intolerance or contraindication to Enbrel, Humira, Rinvoq OR Xeljanz/Xeljanz XR?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                         |
| Q13. Does the patient have a confirmed diagnosis of active ankylosing spondylitis (AS)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q14. Is the patient 18 years of age or older?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |

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|                      |                         |
|----------------------|-------------------------|
| <b>Patient Name:</b> | <b>Prescriber Name:</b> |
|----------------------|-------------------------|

Q15. Is there documentation of inadequate response, intolerance or contraindication to Humira, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR?

Yes

No

Q16. Does the patient have a confirmed diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?

Yes

No

Q17. Is the patient 18 years of age or older?

Yes

No

Q18. Is there documentation of inadequate response, intolerance or contraindication to Rinvoq?

Yes

No

Q19. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2024 Prior Authorization Request