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. Will the patient be taking this drug concomitantly with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD?

☐ Yes ☐ No

Q2. Is the patient within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q3. Is the drug prescribed by or in consultation with a dermatologist, rheumatologist or gastroenterologist?

☐ Yes ☐ No

Q4. Is this a reauthorization request? If YES, go to 5. If NO, go to 6.

☐ Yes ☐ No

Q5. Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

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:**

Q6. Are chart notes attached documenting a diagnosis of moderately to severely active plaque psoriasis? Please attach clinical documentation. If YES, go to 7. If NO, go to 8.

☐ Yes ☐ No

Q7. Is there a documentation of inadequate response, intolerance, or contraindication to at least 1 of the following: methotrexate, UVB therapy, or acitretin? Attach documentation.

☐ Yes ☐ No

Q8. Are chart notes attached documenting a diagnosis of active psoriatic arthritis (PsA)? If YES, go to 9. If NO, go to 10.

☐ Yes ☐ No

Q9. Is there documentation of one of the following:

• Documentation of inadequate response, intolerance, or contraindication to a conventional DMARD (e.g., methotrexate, leflunomide, or sulfasalazine)
• Has axial disease, dactylitis, and /or ethesitis
• Has severe disease as determined by prescriber
• Has concomitant moderate to severe nail disease
• Has concomitant active inflammatory bowel disease

☐ Yes ☐ No

Q10. Are chart notes attached documenting a diagnosis of moderately to severely active Crohn's disease? Please attach clinical documentation. If YES, go to 11. If NO, go to 12.

☐ Yes ☐ No

Q11. Is there documentation of inadequate response, intolerance, or contraindication to one of the following: corticosteroids, methotrexate, 6-mercaptopurine, azathioprine?

☐ Yes ☐ No

Q12. Are chart notes attached documenting a diagnosis of active ulcerative colitis (UC)? If YES, go to 13. If NO, go to 14.

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:**

☐ Yes ☐ No

Q13. Is there documentation of inadequate response, intolerance, or contraindication to at least one corticosteroid?

☐ Yes ☐ No

Q14. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?

☐ Yes ☐ No

Q15. Additional Information:

_____ _____

Prescriber Signature Date

v2025