Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Ustekinumab

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 a request for reauthorization?

☐ Yes - Go to 2 ☐ No - Go to 3

Q2. Is there documentation of improvement in symptoms?

☐ Yes - Go to 16 ☐ No

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

☐ Yes ☐ No

Q4. Is there documentation of tuberculosis (TB) testing that is negative for latent tuberculosis infection OR positive for latent tuberculosis with documentation that treatment is completed or is receiving treatment for latent tuberculosis?

☐ Yes ☐ No

Q5. Is the patient being treated with live vaccines?

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☐ Yes ☐ No

Q6. Does the patient have an active, serious infection?

☐ Yes ☐ No

Q7. Is the patient within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q8. Are chart notes attached showing a diagnosis of moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy?

☐ Yes ☐ No

Q9. Is documentation attached showing inadequate response, intolerance, or contraindication to at least one of the following: methotrexate, UVB therapy, or acitretin?

☐ Yes ☐ No

Q10. Are chart notes attached showing a diagnosis of active psoriatic arthritis?

☐ Yes ☐ No

Q11. Is documentation attached showing: (Select all that apply)

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

Q12. Are chart notes attached showing a diagnosis of moderately to severely active Crohn's disease?

☐ Yes ☐ No

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Q13. Is documentation attached showing inadequate response, intolerance, or contraindication to at least one of the following therapies: corticosteroids, methotrexate, 6-mercaptopurine, azathioprine?

☐ Yes ☐ No

Q14. Are chart notes attached showing a diagnosis of moderately to severely active Ulcerative Colitis?

☐ Yes ☐ No

Q15. Is documentation attached showing inadequate response, intolerance, or contraindication to at least one corticosteroid?

☐ Yes ☐ No

Q16. Is the request for a formulary ustekinumab agent?

☐ Yes ☐ No

Q17. Is documentation attached showing inadequate response, intolerance, or contraindication to all formulary ustekinumab agents that would not be expected to occur with the requested agent?

☐ Yes ☐ No

Q18. Additional Information:

_____ _____

Prescriber Signature Date

v2026