Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Velsipity

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. Request Type:

☐ Initial - Go to 2 ☐ Renewal - Go to 12

Q2. The member is prescribed the requested drug for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication

☐ Yes ☐ No

Q3. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Yes ☐ No

Q4. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. The drug is being prescribed by or in consultation with an appropriate specialist such as a gastroenterologist.

☐ Yes ☐ No

Q6. The member will not take this drug concomitantly with another biologic disease modifying anti-rheumatic drug (DMARD) or a targeted synthetic DMARD.

☐ Yes ☐ No

Q7. In the last 6 months, the member has not experienced a myocardial infarction, unstable angina pectoris, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization, or Class III or IV heart failure.

☐ Yes ☐ No

Q8. The member does not have a history or presence of Mobitz type II second-degree or third-degree AV block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker.

☐ Yes ☐ No

Q9. The member will not receive live vaccines within 4 weeks of starting Velsipity and during treatment with Velsipity.

☐ Yes ☐ No

Q10. Chart notes are attached with documentation of a diagnosis of moderately to severely active ulcerative colitis (UC).

☐ Yes ☐ No

Q11. For a non-formulary agent with a therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that is included on the plan's formulary, has a history of therapeutic failure, contraindication, or an intolerance to the formulary therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that would not be expected to occur with the requested drug.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No ☐ NA

Q12. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q13. The drug is being prescribed by or in consultation with an appropriate specialist such as a gastroenterologist.

☐ Yes ☐ No

Q14. The member will not take this drug concomitantly with another biologic disease modifying anti-rheumatic drug (DMARD) or a targeted synthetic DMARD.

☐ Yes ☐ No

Q15. In the last 6 months, the member has not experienced a myocardial infarction, unstable angina pectoris, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization, or Class III or IV heart failure.

☐ Yes ☐ No

Q16. The member does not have a history or presence of Mobitz type II second-degree or third-degree AV block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker.

☐ Yes ☐ No

Q17. The member will not receive live vaccines during treatment with Velsipity.

☐ Yes ☐ No

Q18. The member has experienced improvement in disease activity and/or level of functioning since initiating therapy with the requested drug.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q19. For a non-formulary agent with a therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that is included on the plan's formulary, has a history of therapeutic failure, contraindication, or an intolerance to the formulary therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that would not be expected to occur with the requested drug.

☐ Yes ☐ No ☐ NA

Q20. Additional Information:

_____ _____

Prescriber Signature Date

v2025