PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Otezla

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 the drug prescribed by or in consultation with a dermatologist (for psoriatic arthritis or plaque psoriasis) or rheumatologist (for psoriatic arthritis or Behcet's disease)?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is this a request for reauthorization?

☐ Yes ☐ No

Q4. For reauthorization: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

Q5. Is the dosage form appropriate based on the patient's weight?

☐ Yes ☐ No

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Q6. Does the patient have a confirmed diagnosis of plaque psoriasis? Please attach clinical documentation.

☐ Yes ☐ No

Q7. Does the patient have a confirmed diagnosis of active psoriatic arthritis? Please attach clinical documentation

☐ Yes ☐ No

Q8. Does the patient have a confirmed diagnosis of oral ulcers associated with Behcet's Disease? Please attach clinical documentation.

☐ Yes ☐ No

Q9. For plaque psoriasis, Is there documentation that the patient is a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q10. For plaque psoriasis, Is there documentation of inadequate response, intolerance, or contraindication to at least one of the following: methotrexate, UVB therapy, or acitretin?

☐ Yes ☐ No

Q11. For psoriatic arthritis, 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 enthesitis
☐ Has severe disease as determined by prescriber
☐ Has concomitant moderate to severe nail disease
☐ Has concomitant active inflammatory bowel disease

Q12. For oral ulcers associated with Behcet's Disease: Is there a documented history of inadequate response, intolerance or contraindication to colchicine?

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☐ Yes ☐ No

Q13. Additional Information:

______________________________ ____________________

Prescriber Signature Date

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