Jefferson Health Plans

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.

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

☐ Yes ☐ No

Q2. The drug is being prescribed by or in consultation with an appropriate prescriber for the indication requested (e.g., rheumatologist or dermatologist).

☐ Yes ☐ No

Q3. The member will not be using the requested drug with biologic disease-modifying antirheumatic drug (DMARDs) or tumor necrosis factor (TNF) blocker.

☐ Yes ☐ No

Q4. Is the request for reauthorization of the requested drug? If YES, go to 12. If NO, go to 5.

☐ Yes ☐ No

Q5. The drug is prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication.

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☐ Yes ☐ No

Q6. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q7. For treatment of PsO, psoriasis associated with at least one of the following:

a. A body surface area (BSA) of 3% or more that is affected,
b. A BSA of less than 3% that is affected with involvement of critical areas (e.g., hands, feet, scalp, face, genitals, nails, and intertriginous areas)

☐ Yes ☐ No ☐ NA

Q8. For PsO, the member is a candidate for systemic therapy or phototherapy.

☐ Yes ☐ No

Q9. For PsO, documentation is attached showing inadequate response, intolerance, or contraindication to at least one of the following: UVB therapy, methotrexate, cyclosporine, or acitretin.

☐ Yes ☐ No

Q10. For psoriatic arthritis (PsA), ONE of the following:

a. Documentation is attached showing inadequate response, intolerance, or contraindication to an 8 week trial of a conventional non-biologic DMARD,
b. Has axial disease, dactylitis, and/or enthesitis,
c. Has severe disease as determined by the prescriber,
d. Has concomitant moderate to severe nail disease,
e. Has concomitant active inflammatory bowel disease.

☐ Yes ☐ No ☐ NA

Q11. For ankylosing spondylitis (AS) or non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation in adult patients, documentation is attached showing inadequate

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response, intolerance, or contraindication to a 2 week trial of continuous treatment with two different oral NSAIDs (e.g., an oral NSAID taken daily for two weeks and a different oral NSAID taken daily for two weeks).

☐ Yes ☐ No

Q12. The member experienced improvement in disease activity and/or level of functioning since initiating therapy.

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

v2026