

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Taltz - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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: <input type="checkbox"/> Medicare	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 applying the 72 hour 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.**

<p>Q1. Is this a reauthorization request?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is there confirmation of continued positive clinical response since starting Taltz?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the medication prescribed by or in consultation with a dermatologist or rheumatologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is there a confirmation of tuberculosis (TB) screening results and treatment plan for active or latent infection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis (PsO)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<p>Q6. Is the patient 6 to 17 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is there documentation of an inadequate response, intolerance or contraindication to Enbrel?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Is there documentation of an inadequate response, intolerance or contraindication to Humira, Enbrel OR Skyrizi?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Does the patient have a confirmed diagnosis of active psoriatic arthritis (PsA)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Is there documentation of inadequate response, intolerance or contraindication to Enbrel, Humira, Rinvoq OR Xeljanz/Xeljanz XR?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q13. Does the patient have a confirmed diagnosis of active ankylosing spondylitis (AS)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q14. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<p>Q15. Is there documentation of inadequate response, intolerance or contraindication to Humira, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q16. Does the patient have a confirmed diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q17. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q18. Is there documentation of inadequate response, intolerance or contraindication to Rinvoq?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q19. Requested Duration:</p> <p><input type="checkbox"/> 12 Months <input type="checkbox"/> Other:</p>
<p>Q20. Additional Information:</p>

Prescriber Signature

Date

2024 Medicare Prior Authorization Request